Module 12:

Medicaid & the Children's Health Insurance Program (CHIP)

National Medicare
TRAINING PROGRAM

...helping people with Medicare make informed health care decisions

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Centers for Medicare & Medicaid Services
National Train-the-Trainer Workshops
Instructor Information Sheet
Module 12
Medicaid & the Children's Health Insurance Program (CHIP)

Module Description
Medicaid & the Children's Health Insurance Program (CHIP) explains programs for people with limited income and resources.

The materials—up-to-date and ready-to-use—are designed for information givers/trainers that are familiar with the Medicare program, and would like to have prepared information for their presentations. Where applicable, updates from recent legislation are included.

The following sections are included in this module:

Slides	Topics
2	Lessons
3-36	Medicaid
27-34	CHIP
35-42	New Eligibility Group
43-47	Medicare Savings Programs
48-50	Information Sources

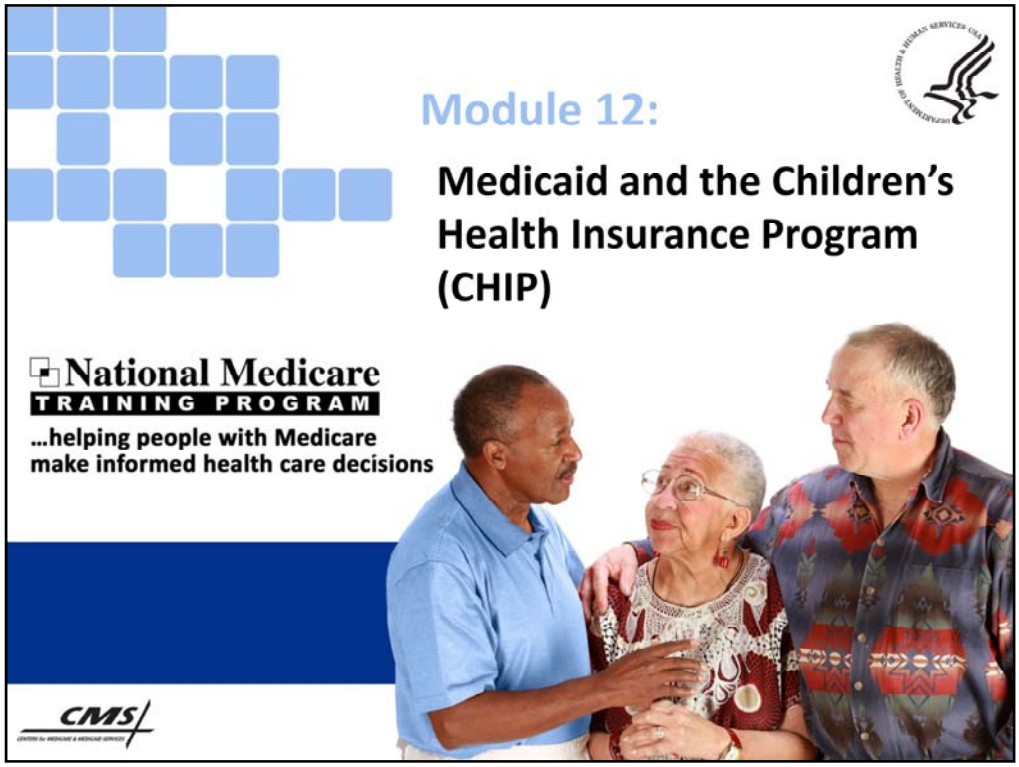
Objectives
- Define Medicaid
- Describe the Children's Health Insurance Program (CHIP)
- Explain the New Eligibility Group
- Identify Medicare Savings Programs (MSP)
- Offer information sources

Target Audience
This module is designed for presentation to trainers and other information givers. It is suitable for presentation to groups of beneficiaries.

Handouts
Slides 31, 39, and 45/46 are provided as full page handouts in the Appendix of this workbook. Also included is a copy of the letter from CMS to State Health Official/State Medicaid Directors Re: New Option for Coverage of Individuals under Medicaid, dated April 9, 2010. You may want to refer to these during your training if you provide copies of the workbooks to attendees. Or, you may wish to make copies of the handouts and distribute them as learning aids.

Time Considerations
The module consists of 50 PowerPoint slides with corresponding speaker's notes. It can be presented in 1 hour. Allow approximately 30 more minutes for discussion, questions and answers.

References
For more information on Medicaid and the Children's Health Insurance Program (CHIP) visit www.medicaid.gov
For more information on the Social Security Act visit www.ssa.gov/OP_Home/ssact/comp-ssa.htm
For more information on Health Care Reform, visit www.Healthcare.gov



Module 12 explains *Medicaid & the Children's Health Insurance Program (CHIP).*

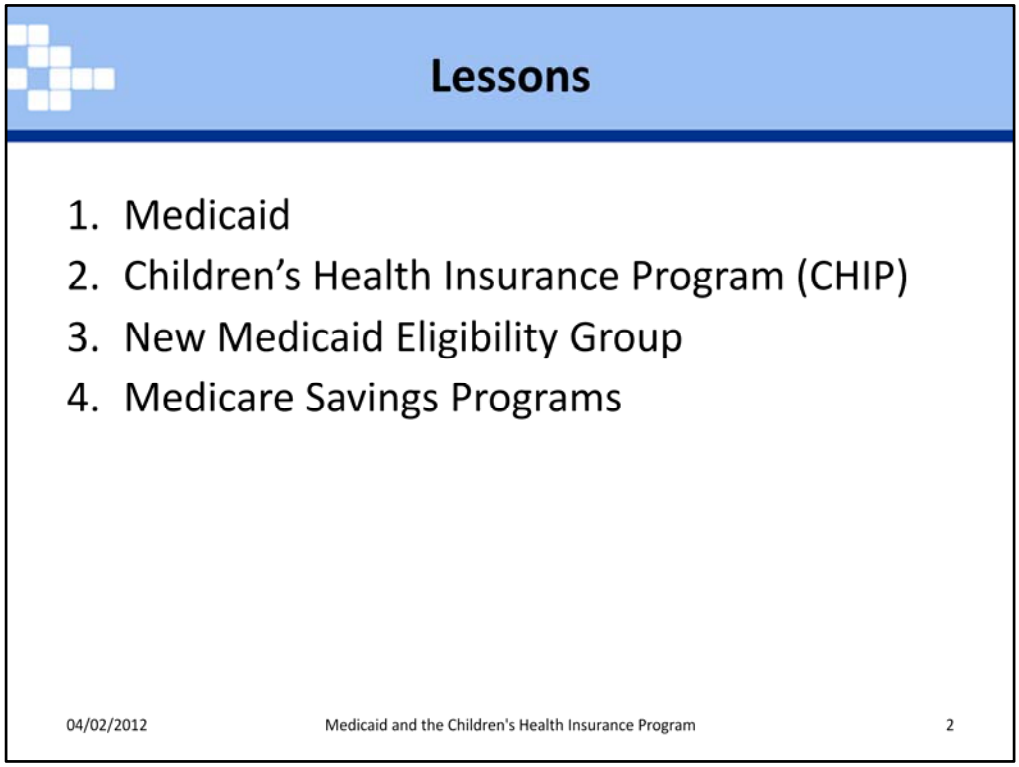
This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP).

The information in this module was correct as of April 2012.

To check for updates on health care reform, visit www.Healthcare.gov.

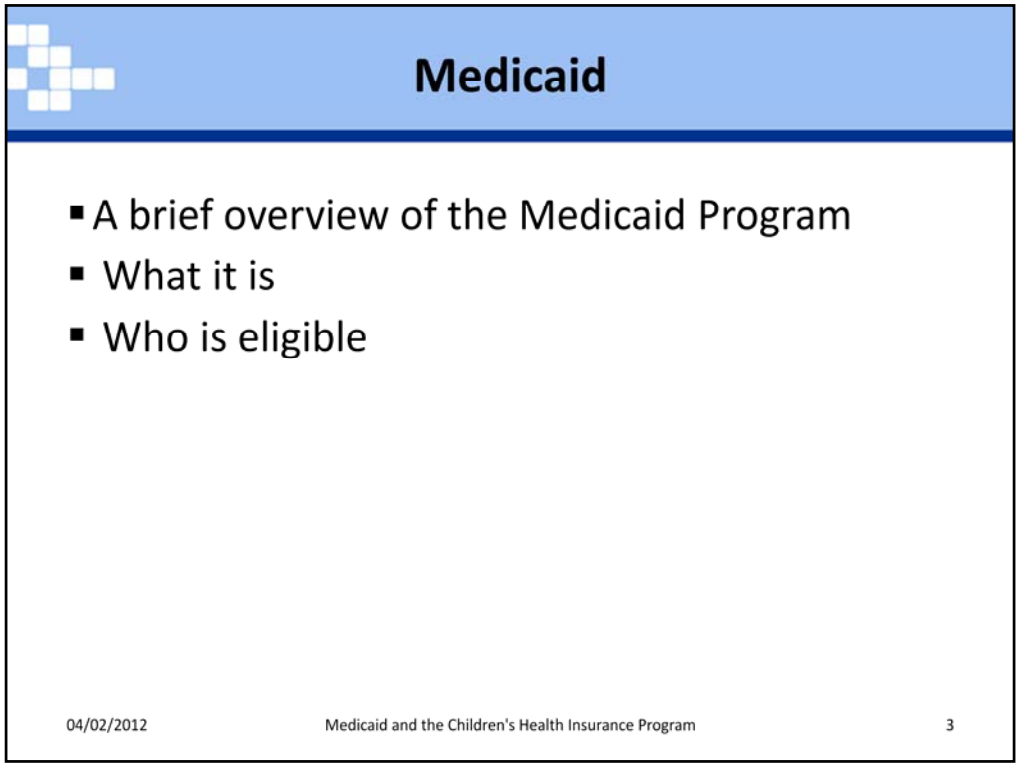
To check for an updated version of this training module, visit http://www.cms.gov/Outreach-and-Education/Training/NationalMedicareProgTrain/Training-Library.html .

This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.



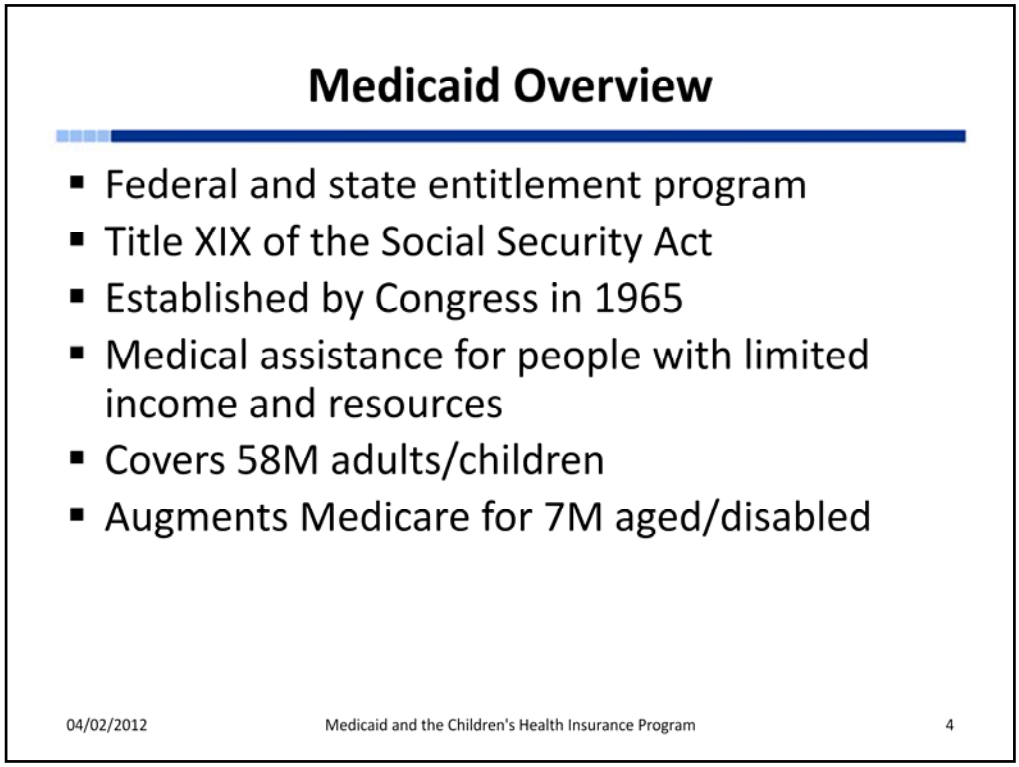
This module includes the following lessons:

1. Medicaid
2. Children's Health Insurance Program (CHIP)
3. New Medicaid Eligibility Group
4. Medicare Savings Programs



This section includes an overview of the Medicaid program:

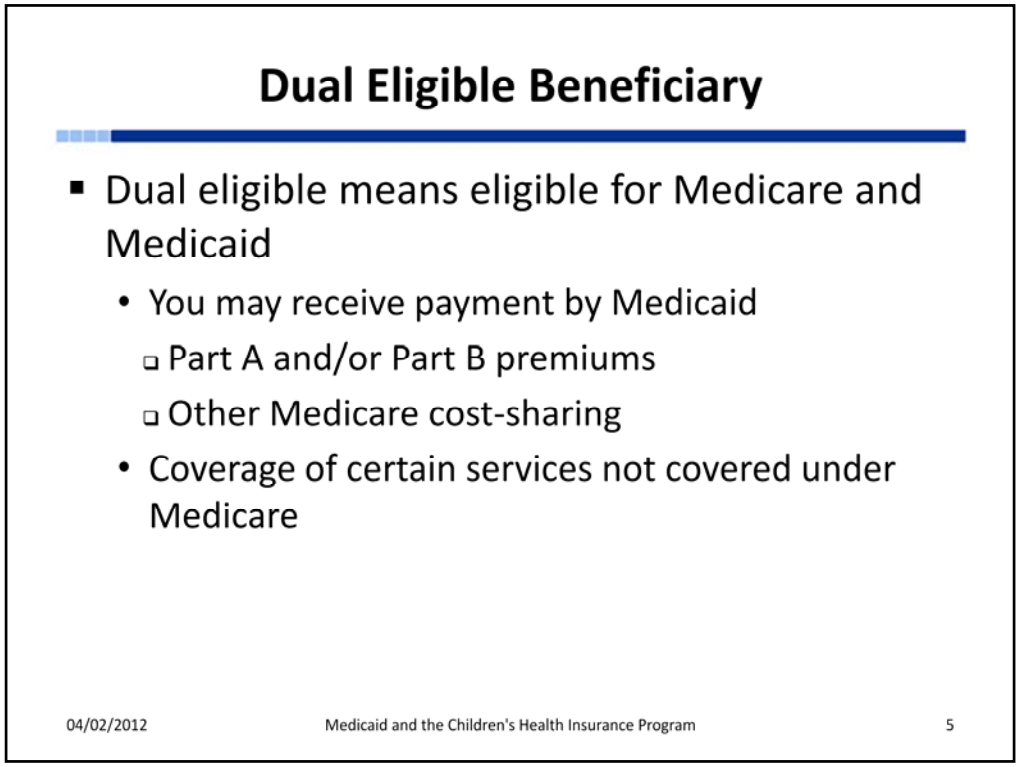
- What it is
- Who is eligible



The Medicaid Program, Title XIX (19) of the Social Security Act, is a Federal and state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources.

The program became law in 1965 as a cooperative venture jointly funded by the Federal and state governments (including the District of Columbia and the Territories), to assist states in furnishing medical assistance to eligible needy persons.

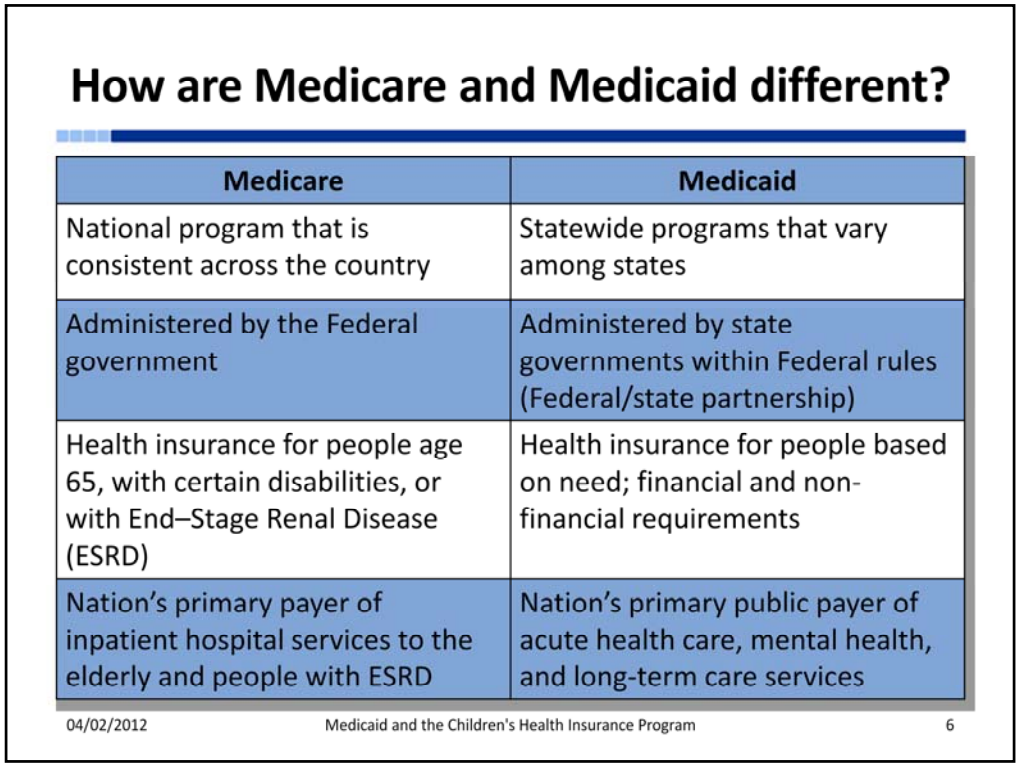
Medicaid is the largest source of funding for medical and health-related services for America's poorest people.



Dual eligible means you are eligible for Medicare and Medicaid.

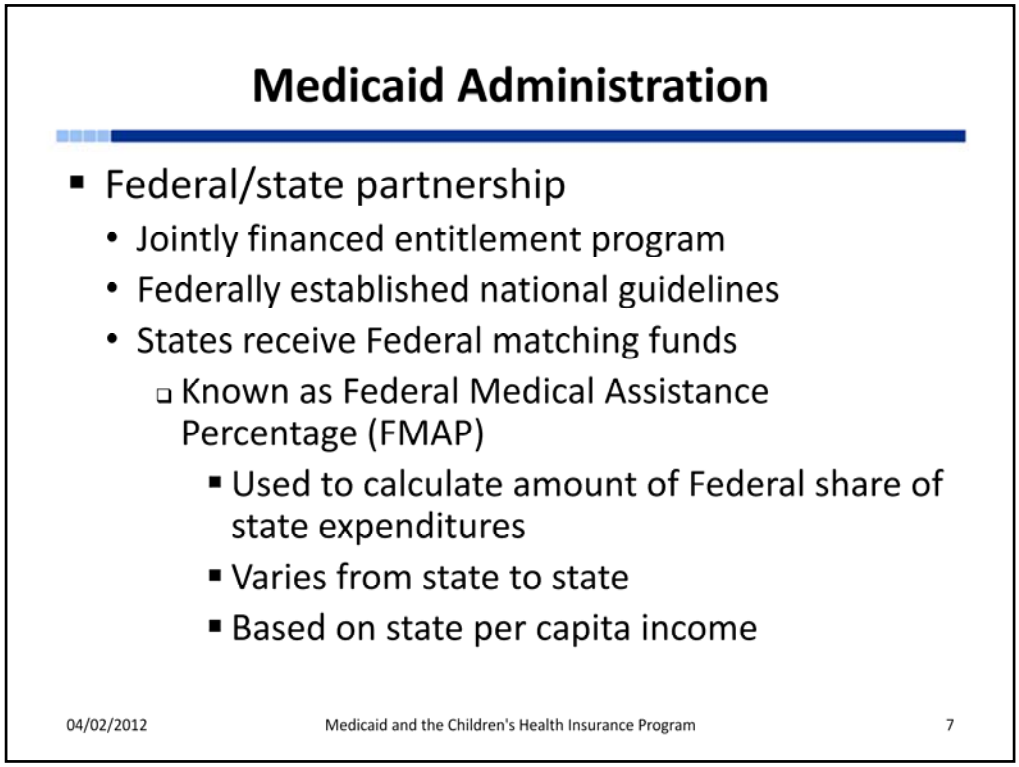
Dually eligible people may receive

- Payment by Medicaid of Part A and/or Part B premiums, and sometimes other Medicare cost-sharing
- Medicaid coverage of certain services not covered under Medicare

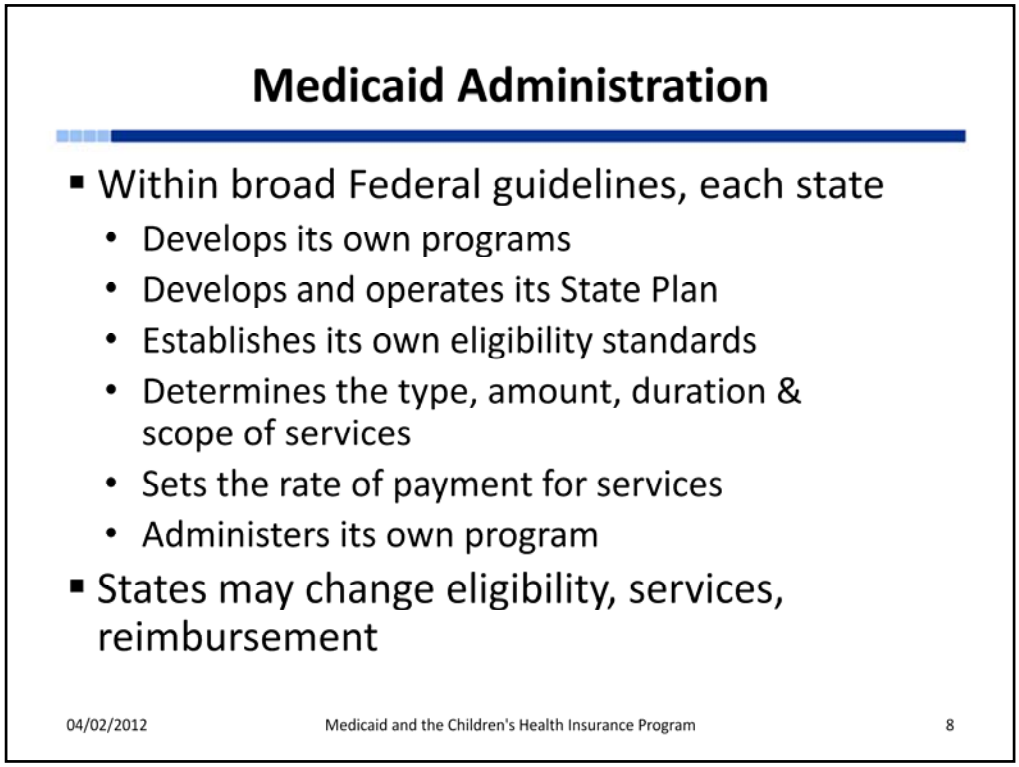


Medicare and Medicaid are different in the following ways:

- While Medicare is a national program that is consistent across the country, Medicaid consists of statewide programs that vary among states.
- While Medicare is administered by the Federal government, Medicaid is administered by state governments within Federal rules (Federal/state partnership).
- While Medicare eligibility is based on age, disability, or End-Stage Renal Disease (ESRD), Medicaid eligibility is based on income and resources.
- While Medicare is the nation's primary payer of inpatient hospital services to the elderly and people with ESRD, Medicaid is the nation's primary public payer of acute health, mental health, and long-term care services.



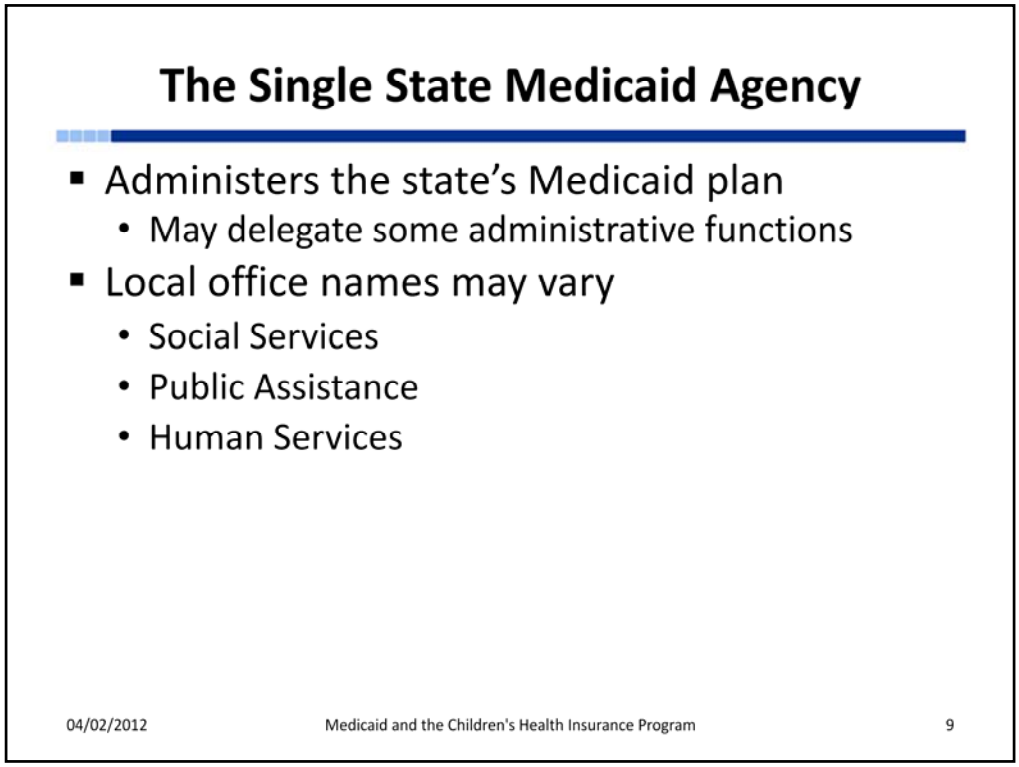
Medicaid is a joint Federal/state partnership program. States receive Federal matching funds for covered services. The Federal matching rate, also known as the Federal Medical Assistance Percentage (FMAP), is used to calculate the amount of Federal share of state expenditures for services. The FMAP varies from state to state based on state per capita income.



Within broad Federal guidelines, each state

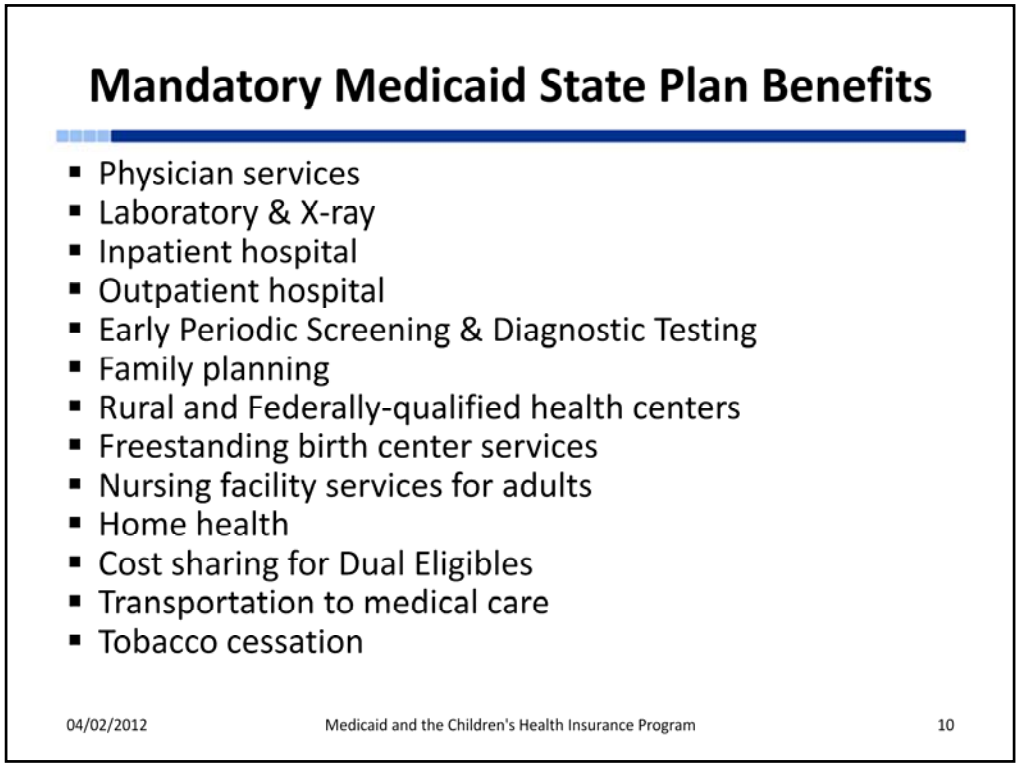
- Develops its own programs
- Develops and operates a State Plan outlining the nature and scope of services
  - The State Plan is a contract between CMS and the state, and any amendments must be approved by CMS
- Establishes its own eligibility standards. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity
  - A person who is eligible for Medicaid in one state may not be eligible in another state.
- Determines the type, amount, duration and scope of services covered. Also, the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state
- Sets the rate of payment for services
- Administers its own program

State legislatures may change Medicaid eligibility, services, and reimbursement during the year.



The Single State Medicaid Agency is responsible for administration of the Medicaid State Plan. The Single State Agency is not required to administer the entire Medicaid program; it may delegate some administrative functions to other state (or local) agencies or private contractors (or both). However, all final eligibility determinations must be made by state (or local) agency personnel.

For more information about eligibility requirements in your state, you may contact the State Medicaid Director in your state. Local office names may vary. To apply for Medicaid, you'll need to contact your local Medicaid Assistance office. These office are sometimes called Social Services, Public Assistance, and Human Services depending on where you live.

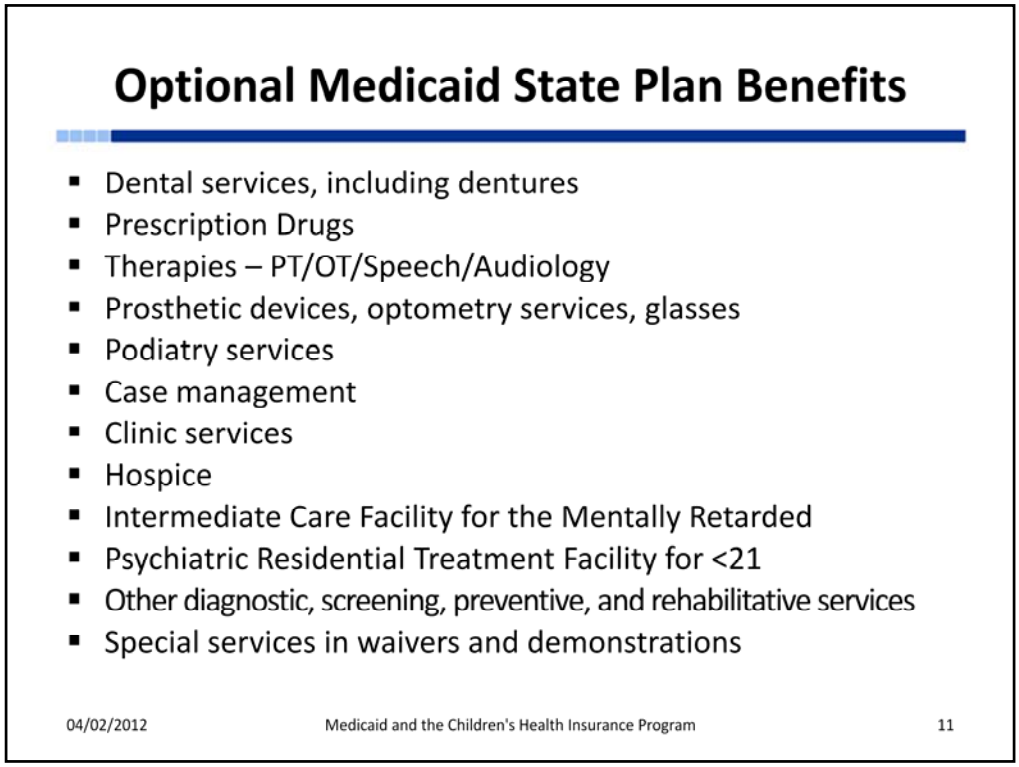


Some Medicaid State Plan benefits are mandatory (must be covered by the state); some are optional (state may choose to cover).

MANDATORY

- Physician services
- Laboratory & X-ray
- Inpatient hospital
- Outpatient hospital
- Early Periodic Screening & Diagnostic Testing (EPSDT)
- Family planning
- Rural and Federally-qualified health centers
- Freestanding birth center services
- Nursing Facility services for adults
- Home health
- Cost sharing for Dual Eligibles
- Transportation to medical care
- Tobacco cessation

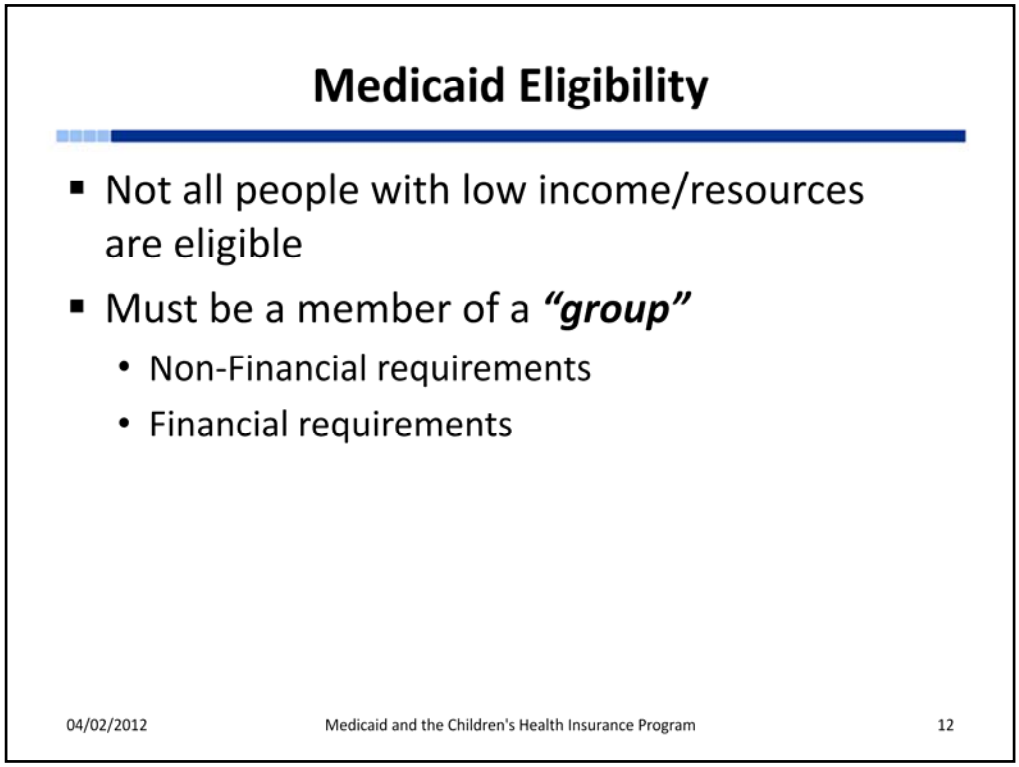
For more information please visit: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html



Optional Medicaid State Plan benefits include

- Dental services, including dentures
- Prescription Drugs
- Therapies – Physical Therapy/Occupational Therapy/Speech/Audiology
- Prosthetic devices, optometry services, glasses
- Podiatry services
- Case management
- Clinic services
- Hospice
- ICF/MR Intermediate Care Facility for the Mentally Retarded
- Psychiatric Residential Treatment Facility for those under age 21
- Other diagnostic, screening, preventative and rehabilitative services
- Special services in waivers and demonstrations

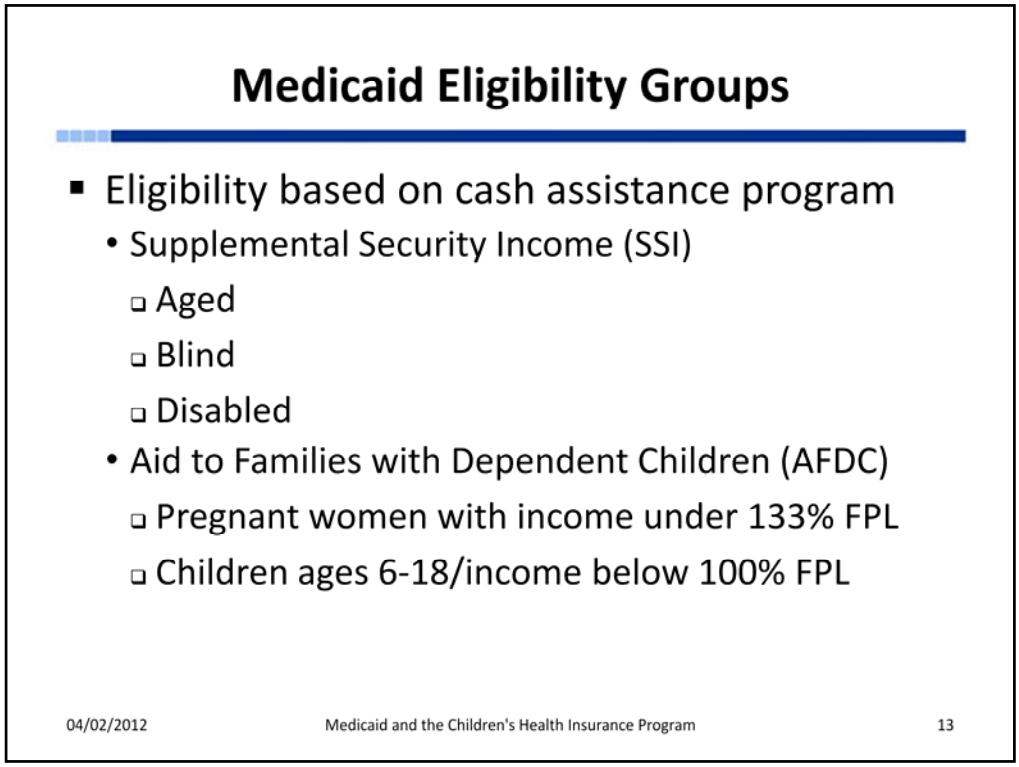
For more information please visit: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html



Not all people with low income/resources are eligible

To be eligible for Medicaid you must be a member of a ***"group"***

- Non-Financial requirements
- Financial requirements

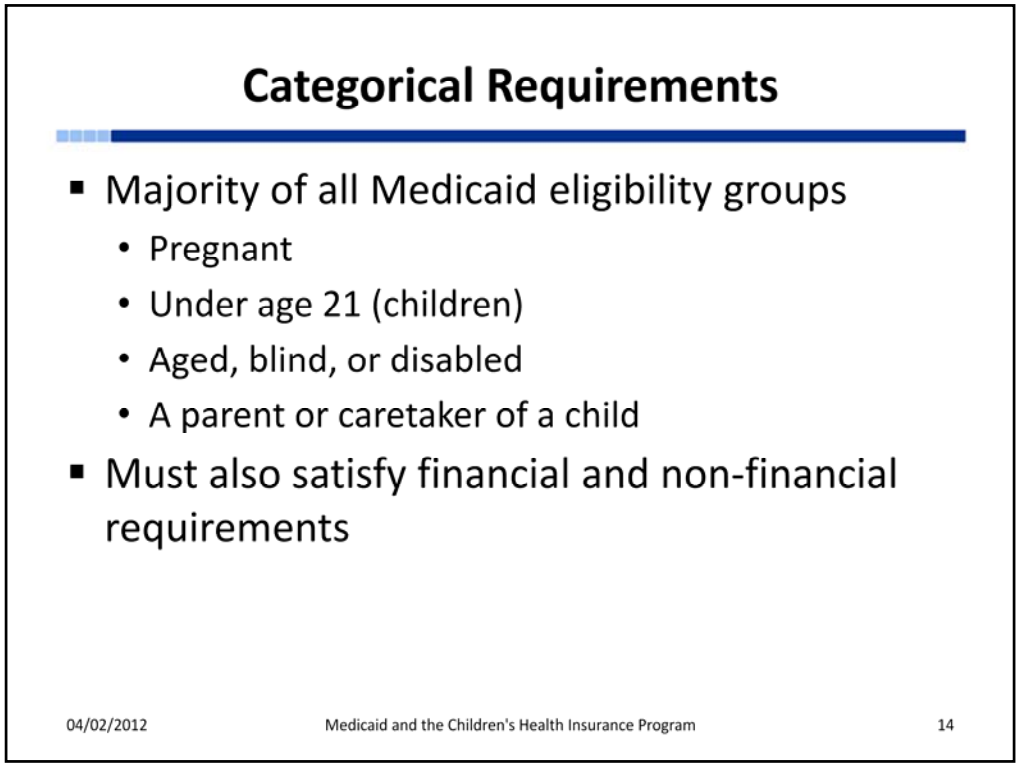


Medicaid eligibility is based on the most closely associated cash assistance program.

- **SSI**: The SSI (Supplemental Security Income) program provides cash benefits to aged, blind or disabled people. It is a means-tested program that has specific rules, requirements, and processes for determining eligibility. Because it is the most closely related cash assistance program for this population, SSI program rules are used to establish Medicaid eligibility for SSI-related groups (persons who are aged, blind or disabled).
- **Aid to Families with Dependent Children (AFDC)**: The AFDC program was replaced with the Temporary Assistance for Needy Families (TANF) program in 1997, but worked almost the same way as the SSI program, but for children, families with dependent children, and pregnant women. Because AFDC was the most closely related cash assistance program for this population, AFDC rules are used to establish Medicaid eligibility for AFDC-related groups (children, families with children, and pregnant women).

Here are a few examples of groups:

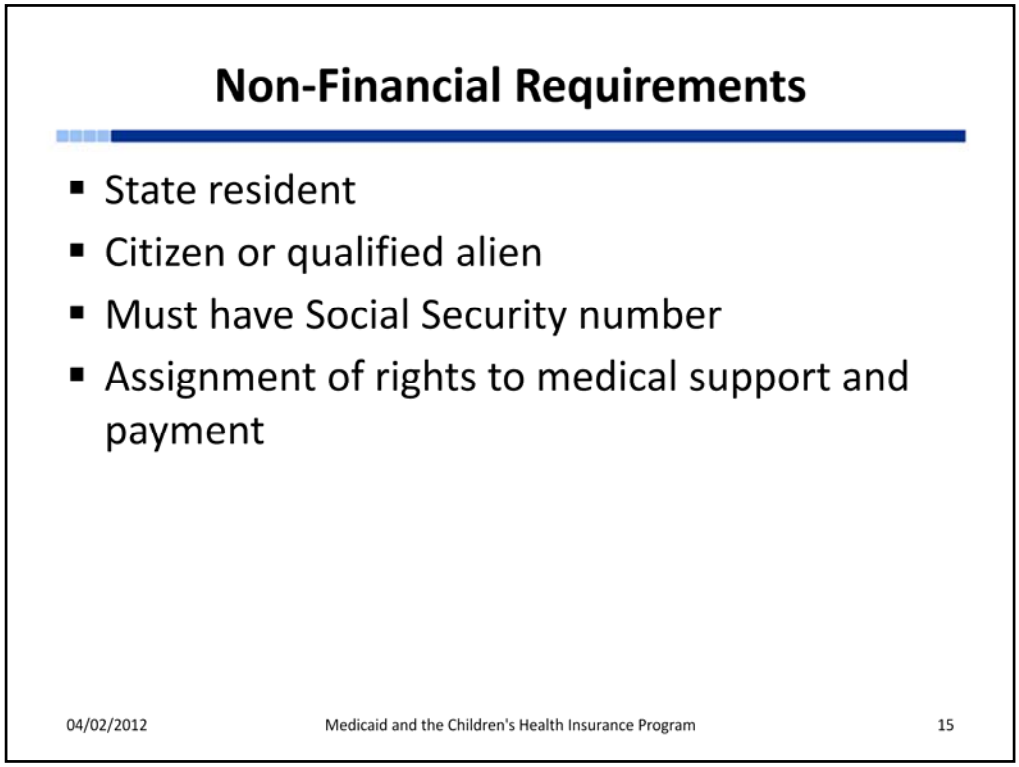
- People receiving SSI benefits
- Pregnant women with income under 133% of the Federal Poverty Level (FPL)
- Children ages 6-18 with income below 100% FPL



Majority of all Medicaid eligibility groups consist of the following individuals:

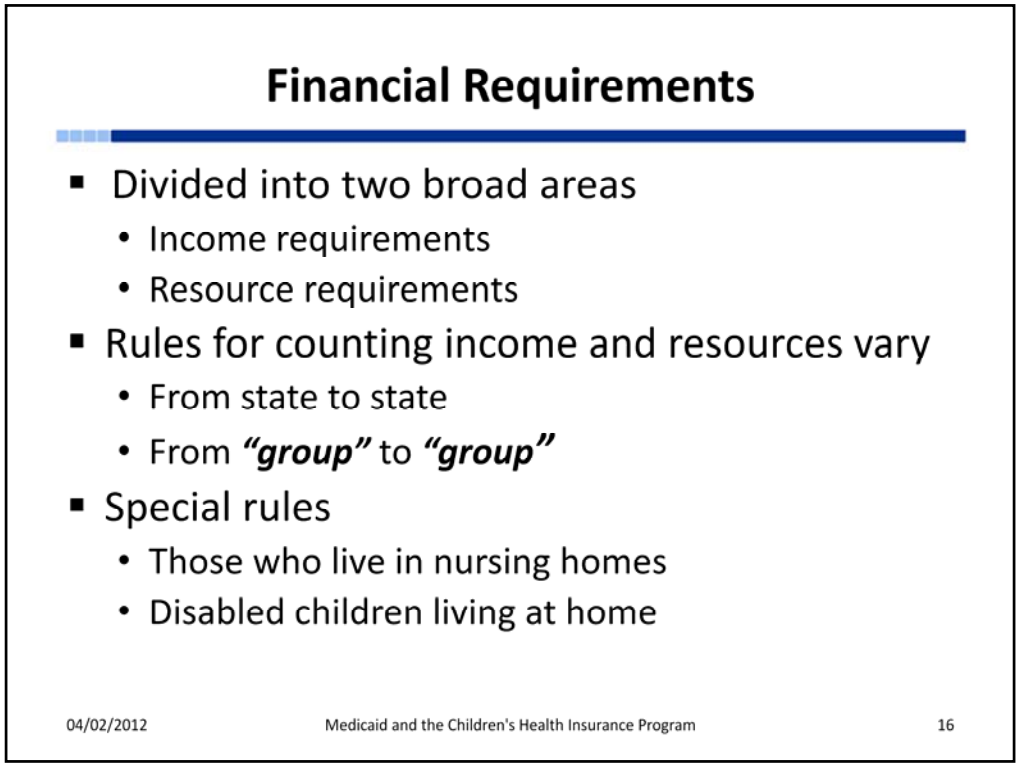
- Pregnant women
- People under age 21 (children)
- People who are aged, blind, or disabled
- A parent or caretaker of a child

To qualify you must also satisfy financial and non-financial requirements.



Non-financial requirements include

- The state you reside in
- Whether you are a citizen or qualified alien
- You must have a Social Security number
- You must assign rights to medical support and payment

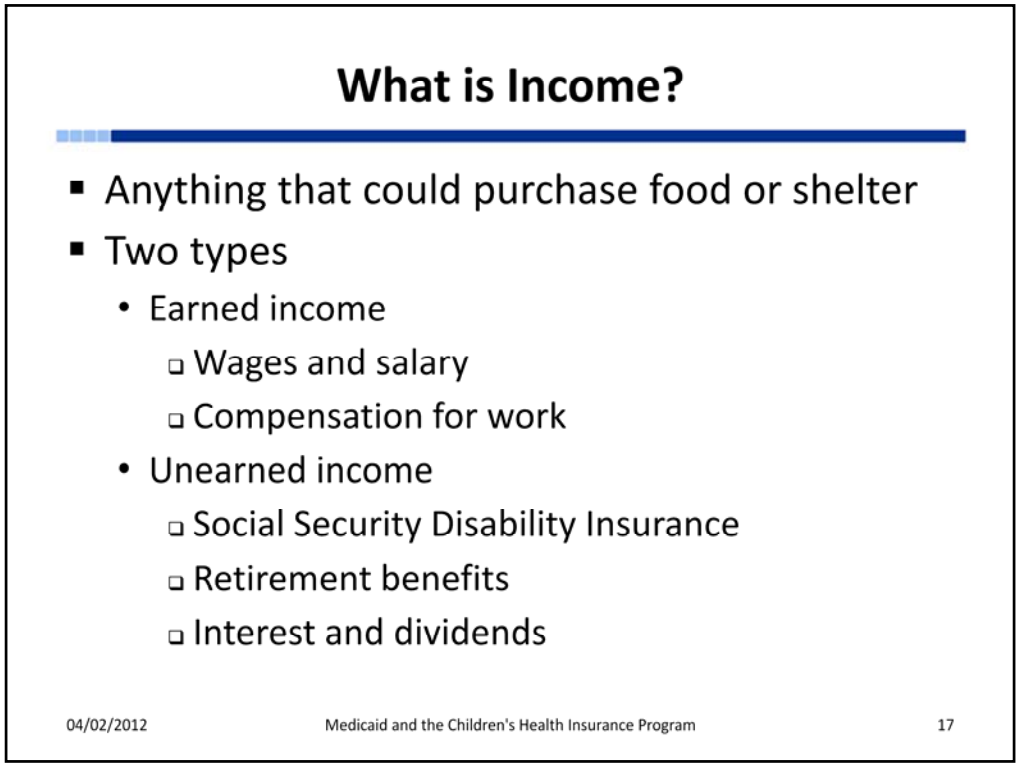


The financial requirements are divided into two broad areas:

- Income requirements
- Resource requirements

The rules for counting your income and resources vary from state to state and from ***"group"*** to ***"group".***

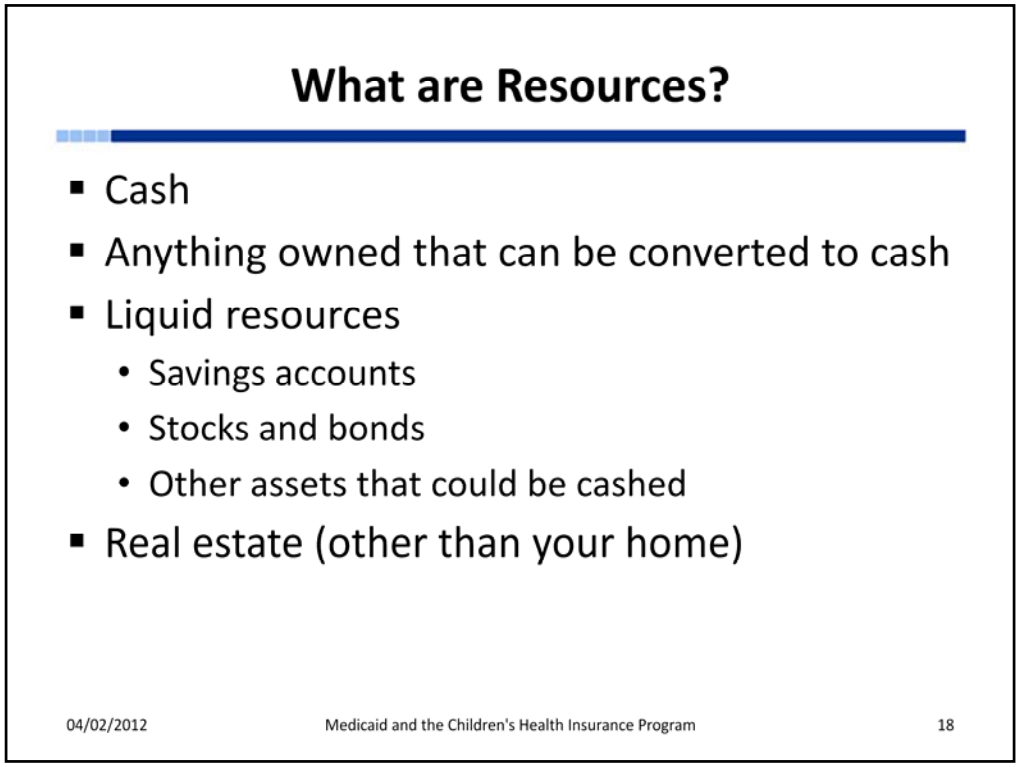
There are special rules for those who live in nursing homes and for disabled children living at home.



Income is anything that you could use to purchase food or shelter.

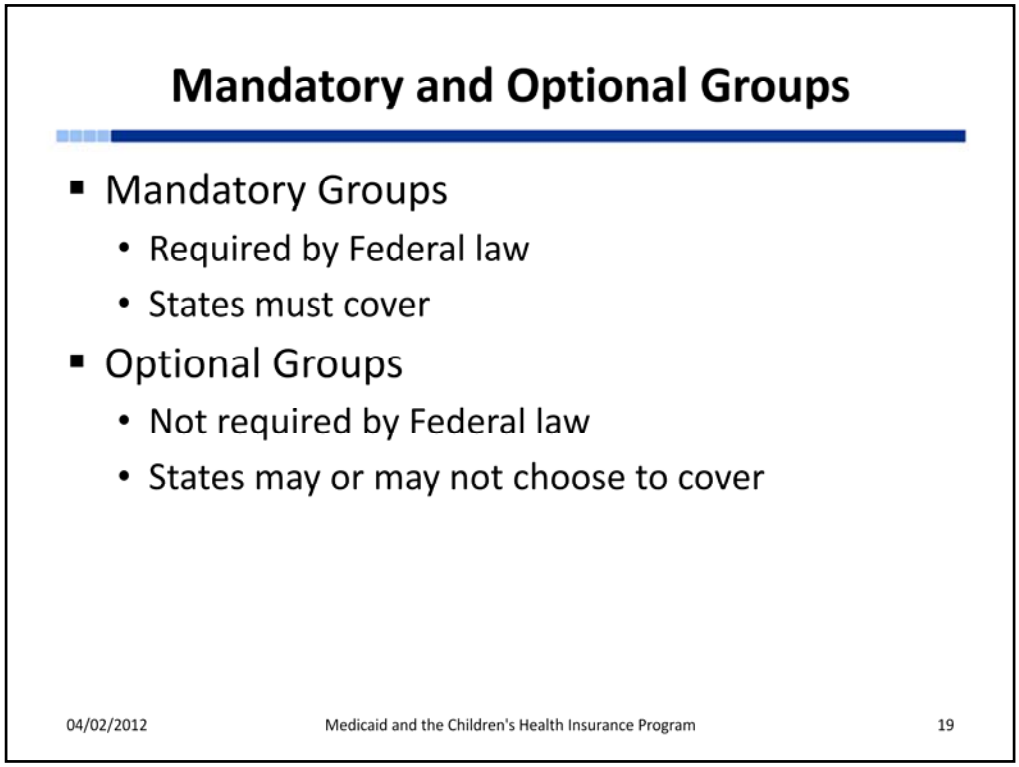
There are two types of income:

- Earned income, such as wages, salary, or any compensation for work
- Unearned income, such as of Social Security Disability Insurance, retirement benefits, and interest and dividends

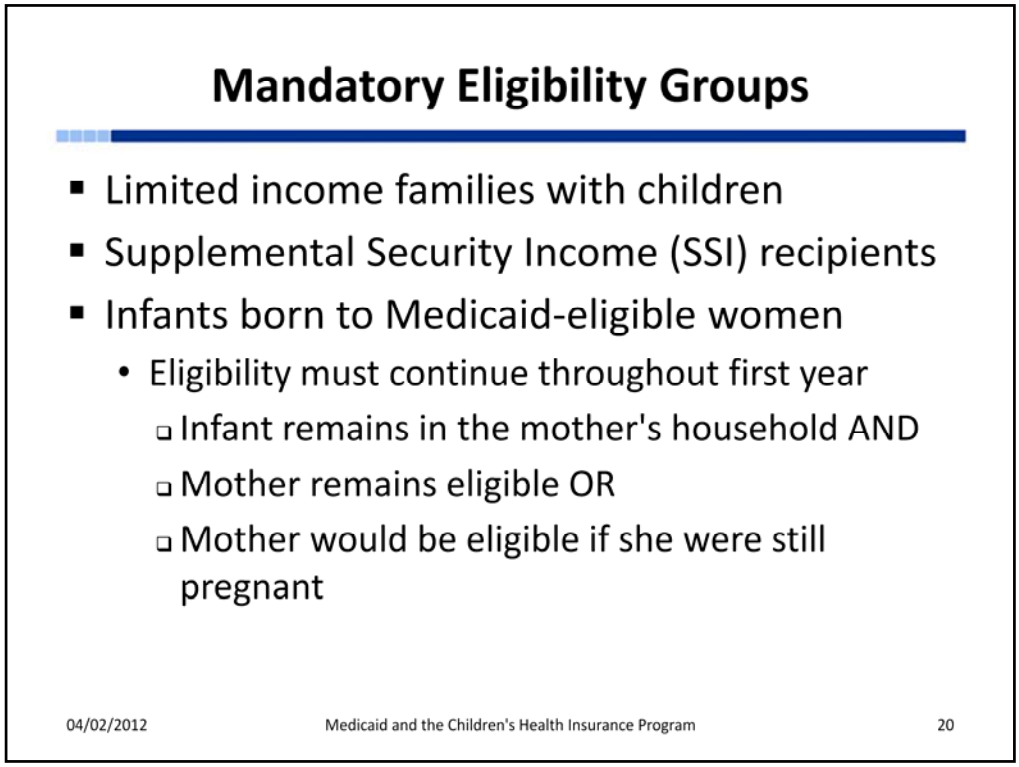


The following are considered resources:

- Cash
- Anything you own that can be converted to cash
- Liquid resources like savings accounts, stocks, bonds, or anything that could be cashed
- Real estate you own, other than your home

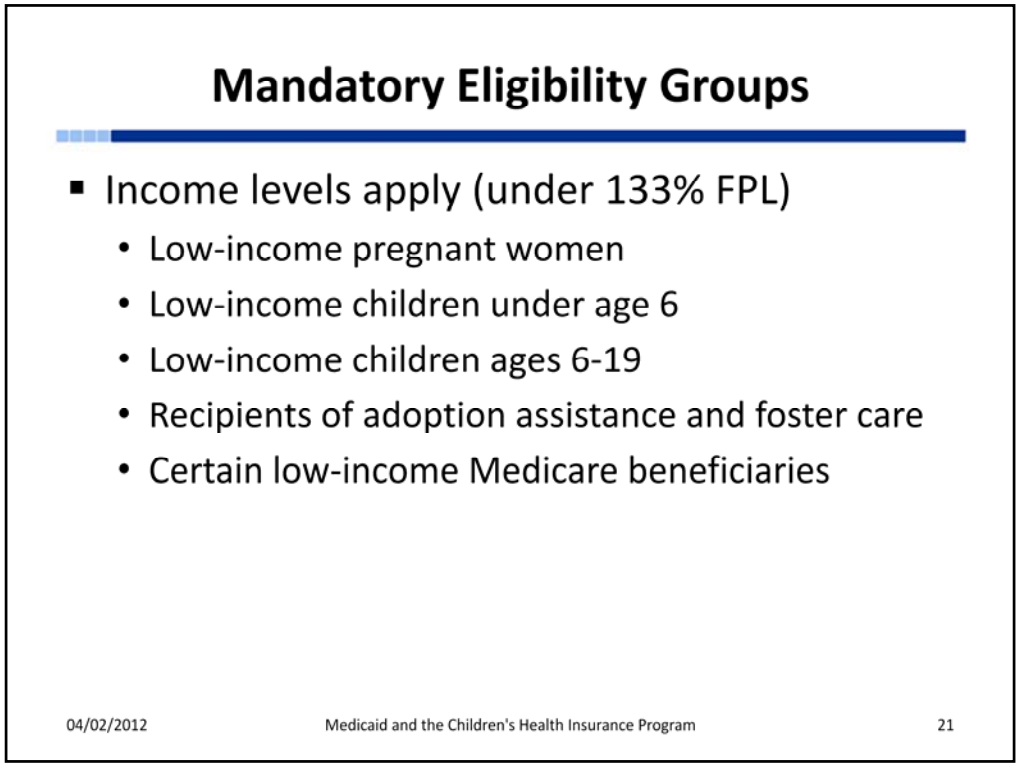


There are mandatory groups and optional groups:



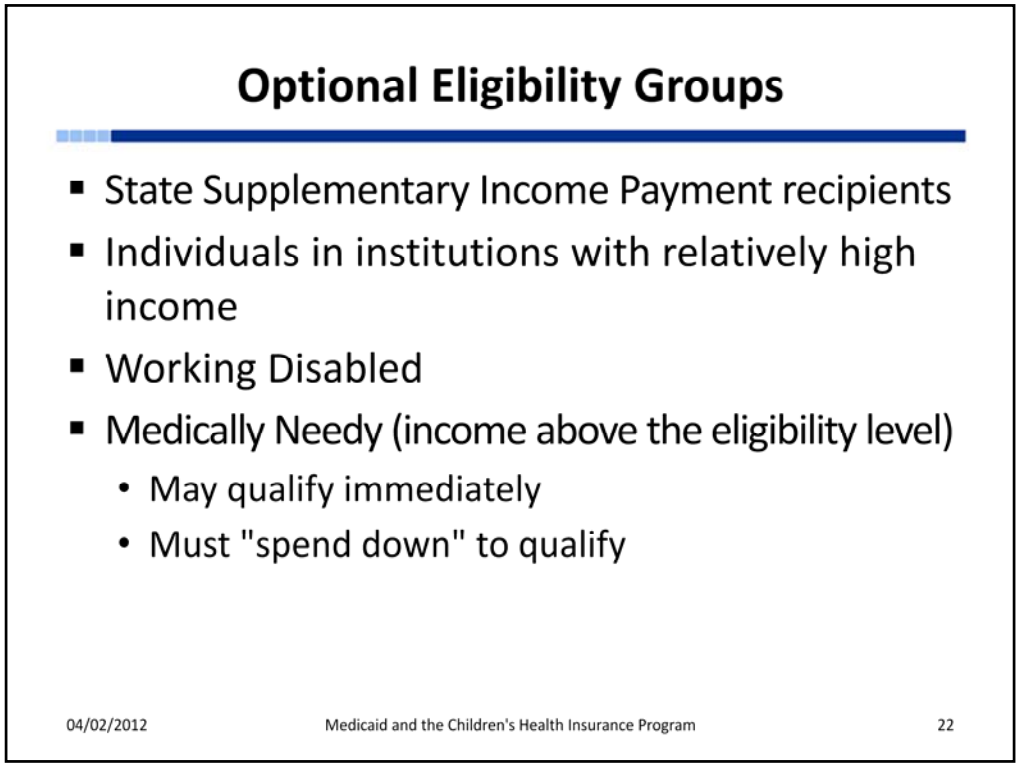
The following specifies the mandatory Medicaid ("categorically needy") eligibility groups for which Federal matching funds are provided:

- Limited income families with children, as described in Section 1931 of the Social Security Act, who meet certain of the eligibility requirements in the state's Aid to Families with Dependent Children (AFDC) plan in effect on July 16, 1996
- Supplemental Security Income (SSI) recipients (or in States using more restrictive criteria--aged, blind, and disabled individuals who meet criteria which are more restrictive than those of the SSI program and which were in place in the state's approved Medicaid plan as of January 1, 1972)
- Infants born to Medicaid-eligible pregnant women - Medicaid eligibility must continue throughout the first year of life so long as the infant remains in the mother's household and she remains eligible, or would be eligible if she was still pregnant.



The groups Federally required to be covered by states include the following:

- Pregnant women and children under age 6 whose family income is at or below 133% of the Federal poverty level (The minimum mandatory income level for pregnant women and infants in certain States may be higher than 133% percent, if as of certain dates the State had established a higher percentage for covering those groups)
  - Once eligibility is established, pregnant women remain eligible for Medicaid through the end of the calendar month in which the 60th day after the end of the pregnancy falls, regardless of any change in family income.
- Children age 6 until age 19 in families with incomes at or below the Federal poverty level
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act
- Certain low-income Medicare beneficiaries



States may provide Medicaid coverage for other optional groups. These optional groups share characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined.

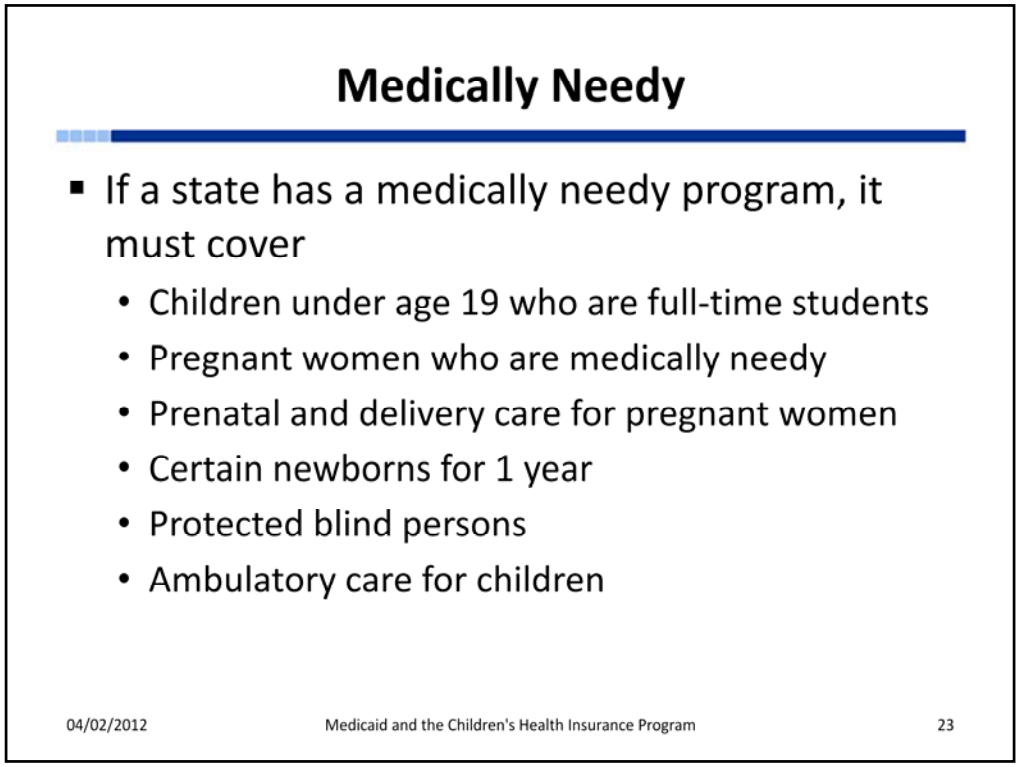
The broadest optional groups for which states will receive Federal matching funds for coverage under the Medicaid program include the following:

- Recipients of state supplementary income payments
- Individuals in institutions with relatively high income
- The Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170) created two new eligibility groups for working disabled individuals. Both are optional for the states, and both went into effect October 1, 2000.

States have the option of extending Medicaid coverage to medically needy individuals who are not otherwise eligible for Medicaid because of excess income. The individual's incurred medical costs are deducted from income over an accounting period of one to six months. If the net result is below the state-established "medically needy" income level, the individual will qualify for Medicaid coverage for the remainder of the accounting period. This can provide access to Medicaid coverage for individuals with recurring drug and medical expenses that are high in relation to their monthly income.

The medically-needy group is an optional group consisting of individuals who would be eligible for Medicaid, except that their income is above a level that would otherwise make them eligible for Medicaid.

- Individuals must "spend down" to qualify



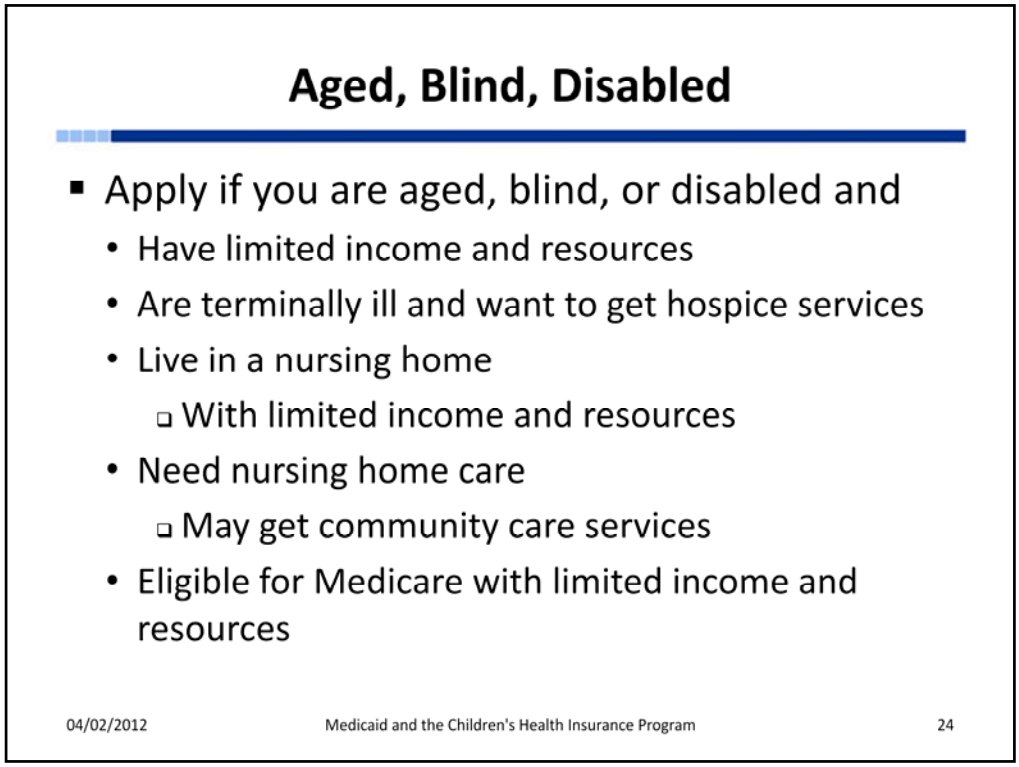
If a state has a medically needy program it must cover the following:

- Children under age 19 who are full-time students
- Pregnant women who are medically needy
- Prenatal and delivery care for pregnant women
- Certain newborns for 1 year
- Protected blind persons (those eligible as medically needy under Medicaid in December 1973 on the basis of the blindness or disability criteria and meet the current requirements for eligibility as medically needy under Medicaid except for blindness or disability criteria)
- Ambulatory care for children

The following states have medically needy programs:

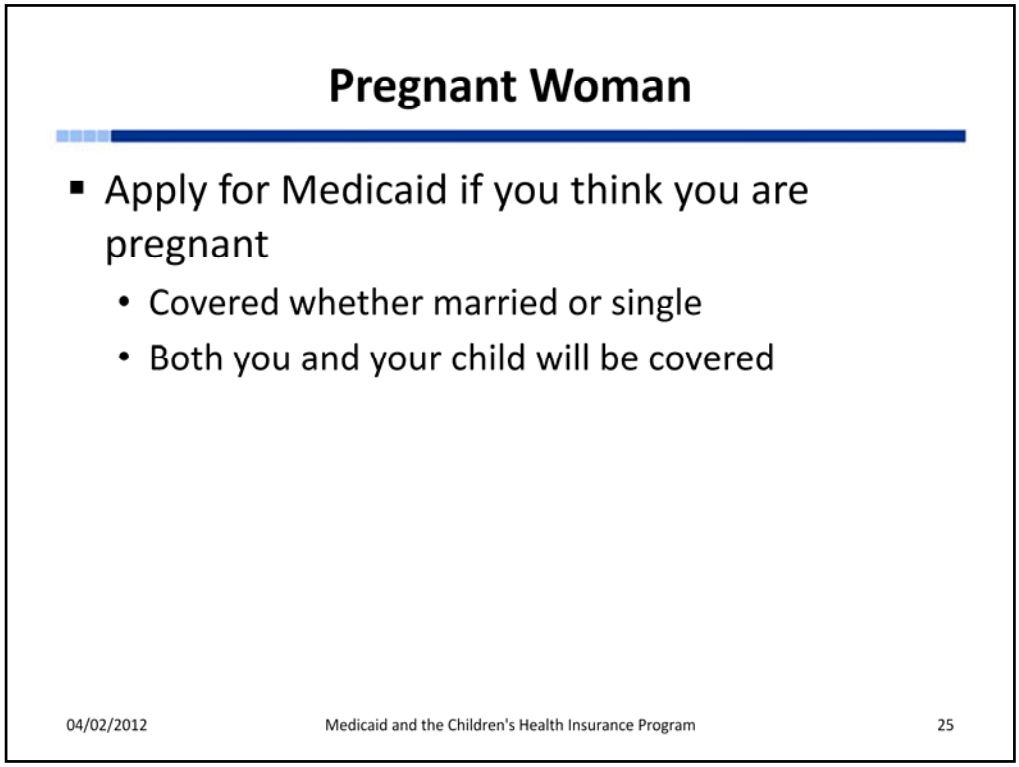
Arkansas, Hawaii, Maine, Nebraska, Pennsylvania, Vermont, California, Illinois, Maryland, New Hampshire, Puerto Rico, Virginia, Connecticut, Iowa, Massachusetts, New Jersey, Rhode Island, Washington, Dist. of Columbia, Kansas, Michigan, New York, Tennessee, West Virginia, Florida, Kentucky, Minnesota, North Carolina, Texas*, Wisconsin, Georgia, Louisiana, Montana, North Dakota, and Utah

**The medically needy program in Texas covers only the "mandatory" medically needy groups. It does not cover the aged, blind and disabled.*

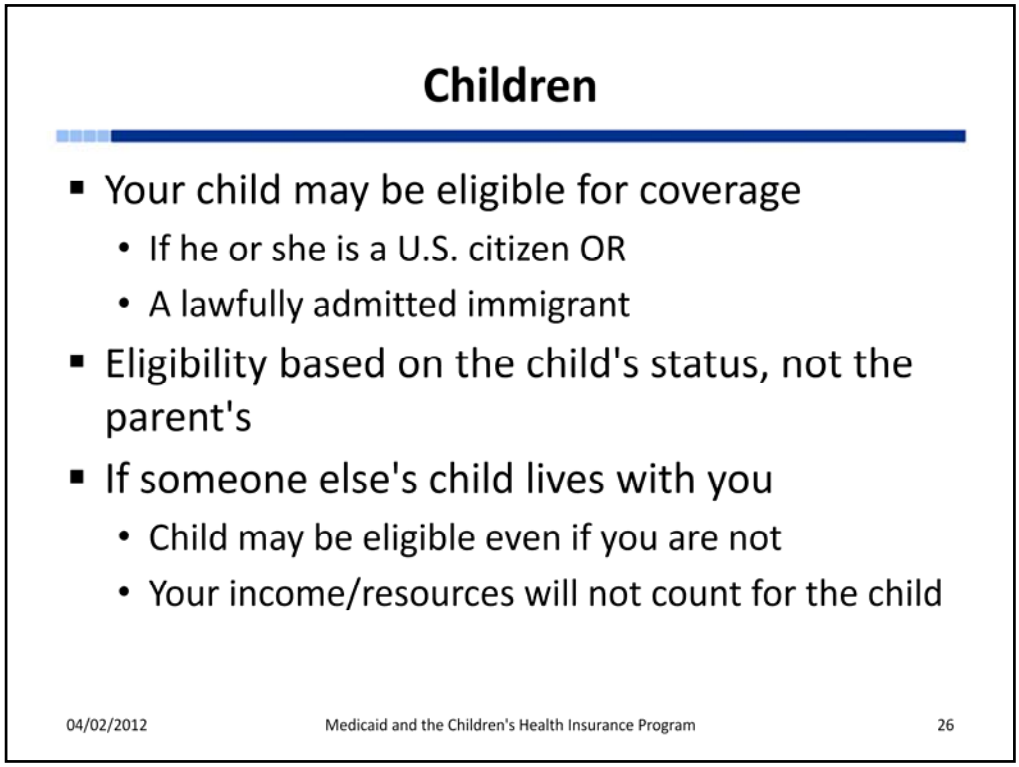


Apply if you are aged (65 years old or older), blind, or disabled and one of the following:

- You have limited income and resources
- You are terminally ill and want to get hospice services
- You live in a nursing home and have limited income and resources
- You need nursing home care, but can stay at home with special community care services
- You are eligible for Medicare and have limited income and resources



Apply for Medicaid if you think you are pregnant. You may be eligible if you are married or single. If you are covered by Medicaid when your child is born, both you and your child will be covered.

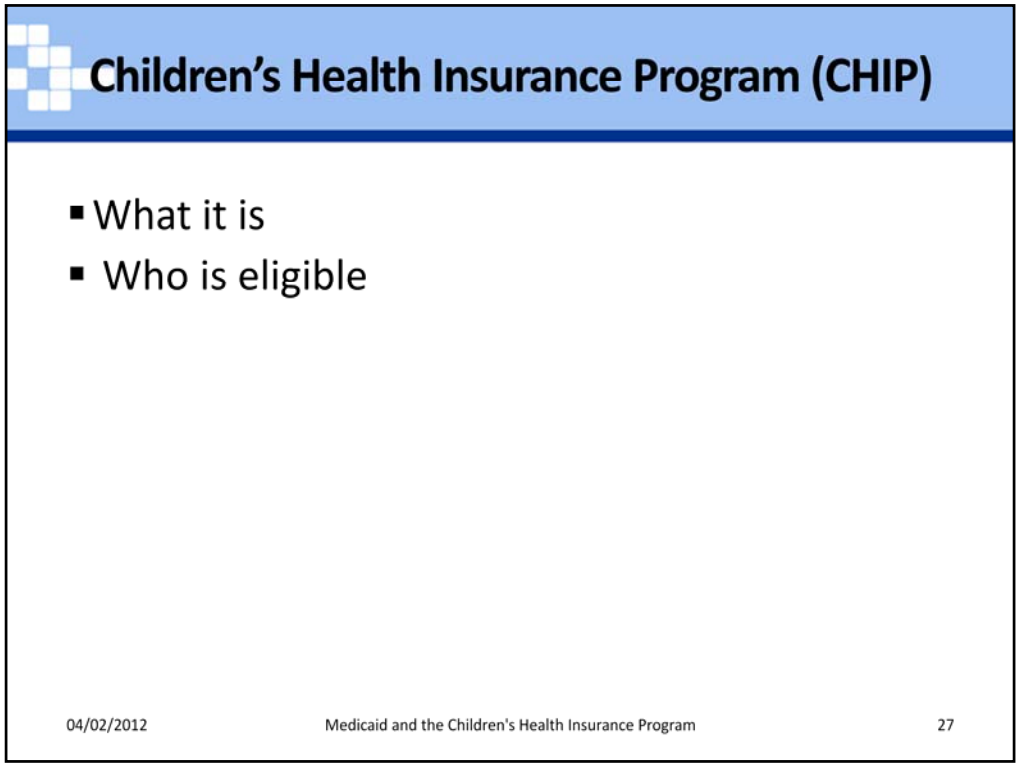


Your child may be eligible for coverage if he or she is a U.S. citizen or a lawfully admitted immigrant, even if you are not (however, there is a 5-year limit that applies to lawful permanent residents).

Eligibility for children is based on the child's status, not the parent's status. Also, if you are caring for someone else's child who lives with you, the child may be eligible even if you are not because your income and resources will not count for the child.

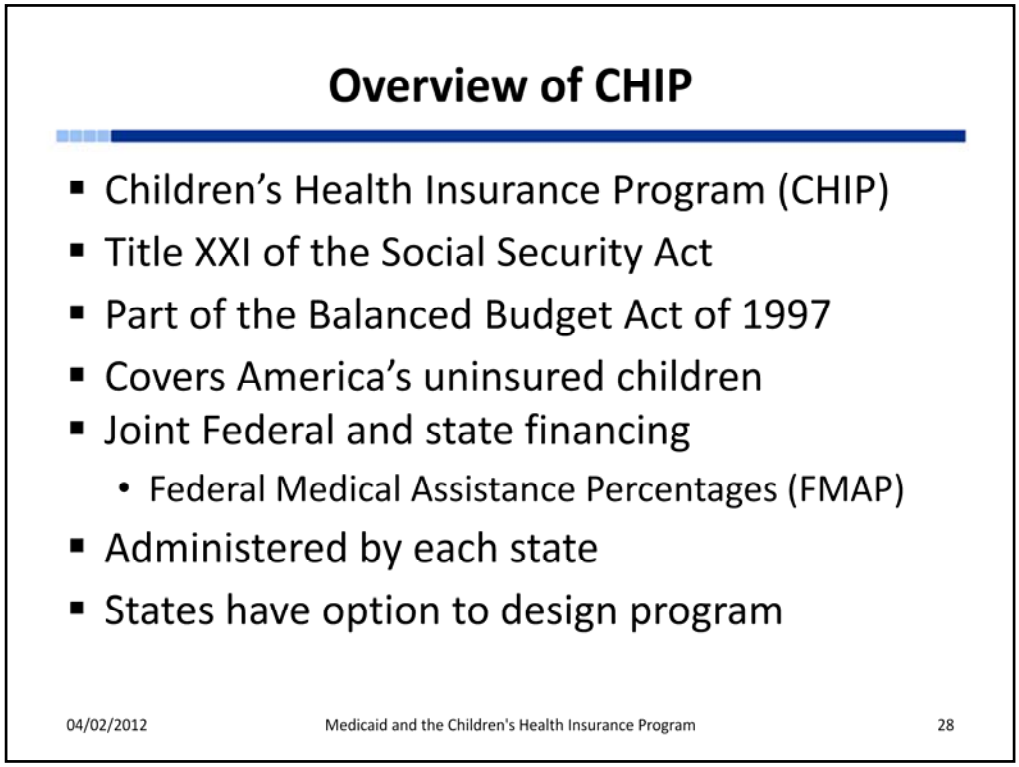
Apply for Medicaid if you are the parent or guardian of a child who is 18 years old or younger and your family's income is limited, or if your child is sick enough to need nursing home care, but could stay home with good quality care at home.

- If you are a teenager living on your own, the state may allow you to apply for Medicaid on your own behalf or any adult may apply for you.
- Many states also cover children up to age 21.



This section explains the Children's Health Insurance Program (CHIP).

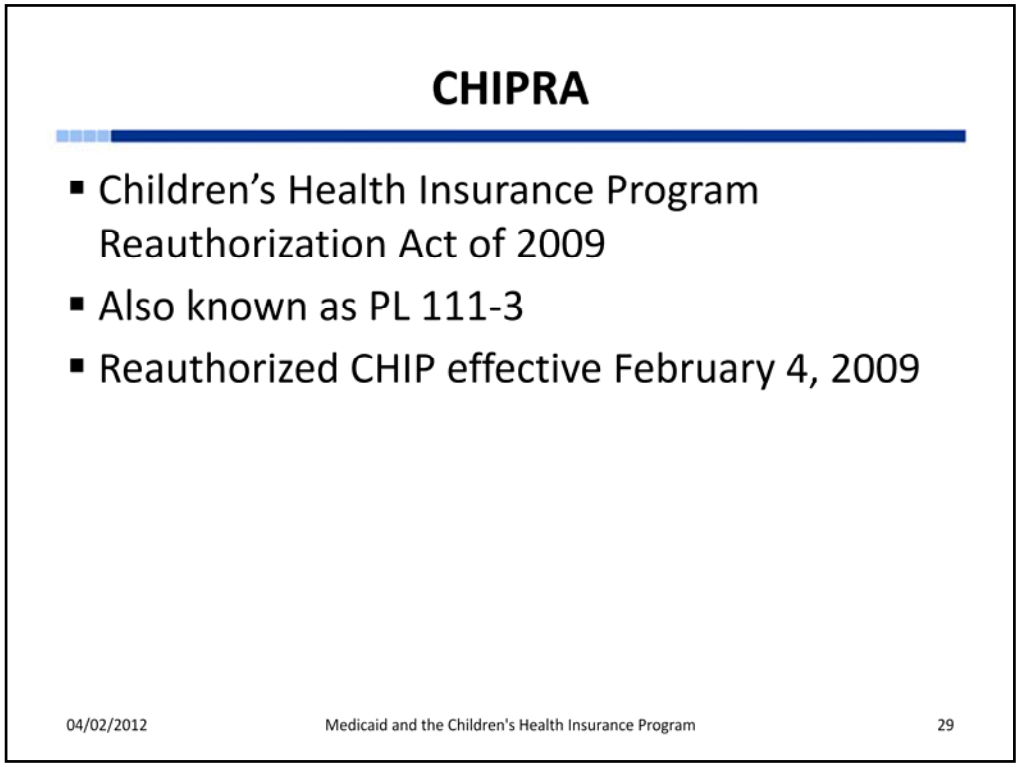
- What it is
- Who is eligible



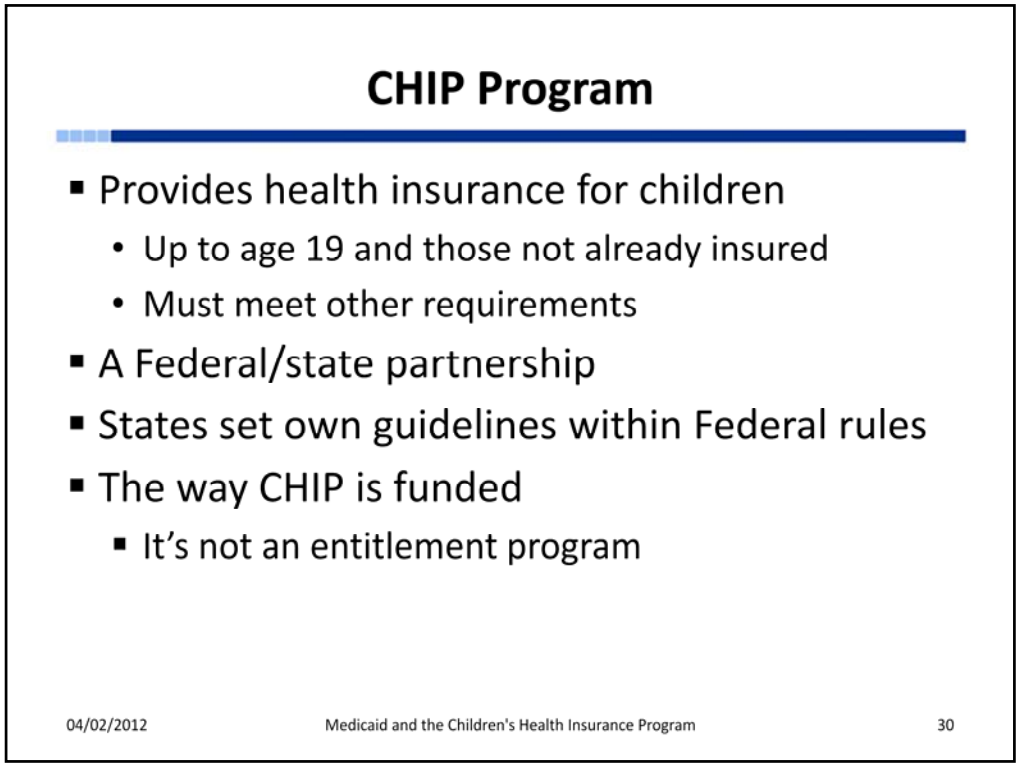
The Children's Health Insurance Program (CHIP), previously called the State Children's Health Insurance Program (SCHIP), was created as part of the Balanced Budget Act of 1997, with strong, bi-partisan support for covering America's uninsured children. This was the largest expansion of public health insurance coverage since the creation of Medicare and Medicaid in 1965. It is under Title XXI (21) of the Social Security Act.

- CHIP is jointly financed by the Federal and state governments and is administered by the states.
- Federal Medical Assistance Percentages (FMAPs) are used in determining the amount of Federal matching funds for state expenditures for assistance payments for certain social services, and state medical and medical insurance expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the FMAPs each year. The "Federal Medical Assistance Percentages" are for Medicaid. Section 1905(b) of the Act specifies the formula for calculating Federal Medical Assistance Percentages. "Enhanced Federal Medical Assistance Percentages" are for the Children's Health Insurance Program (CHIP) under Title XXI (21) of the Social Security Act.
- Within broad Federal guidelines, each state determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. Each state has the option to expand Medicaid, create a stand-alone program, or create a combination program.

More information on CHIP is available at
http://www.cms.gov/CHIPRA/01_Overview.asp#TopOfPage

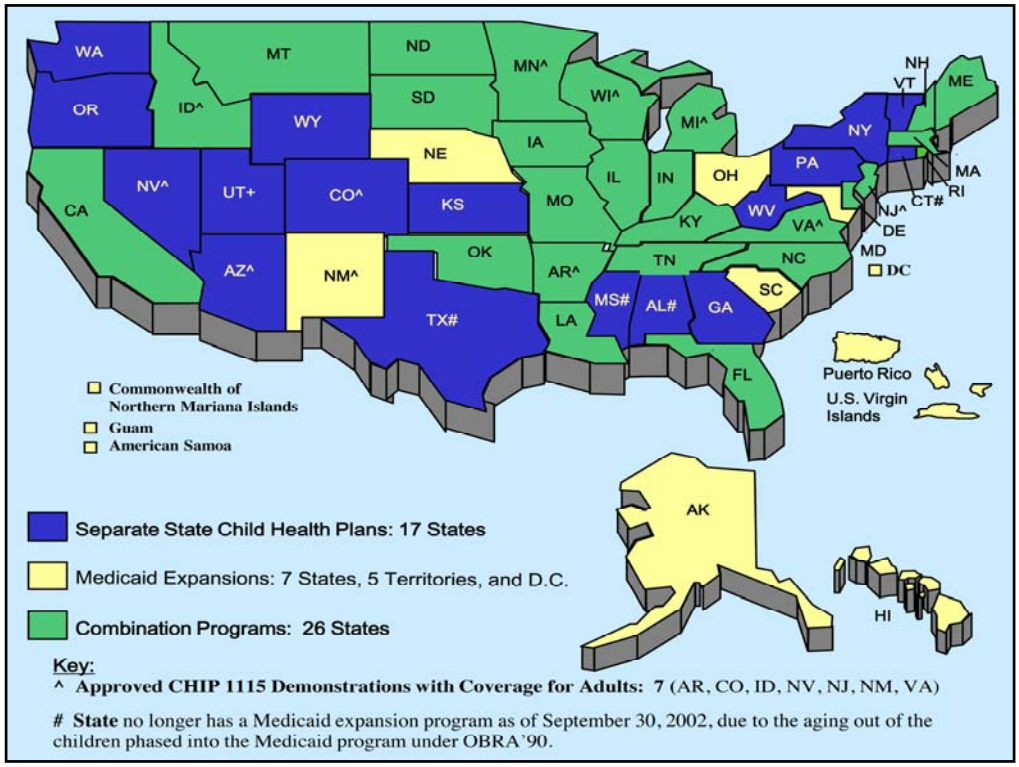


CHIPRA, or the Children's Health Insurance Program Reauthorization Act, reauthorized the CHIP program effective February 4, 2009. CHIPRA is also known as Public Law (PL) 111-3.

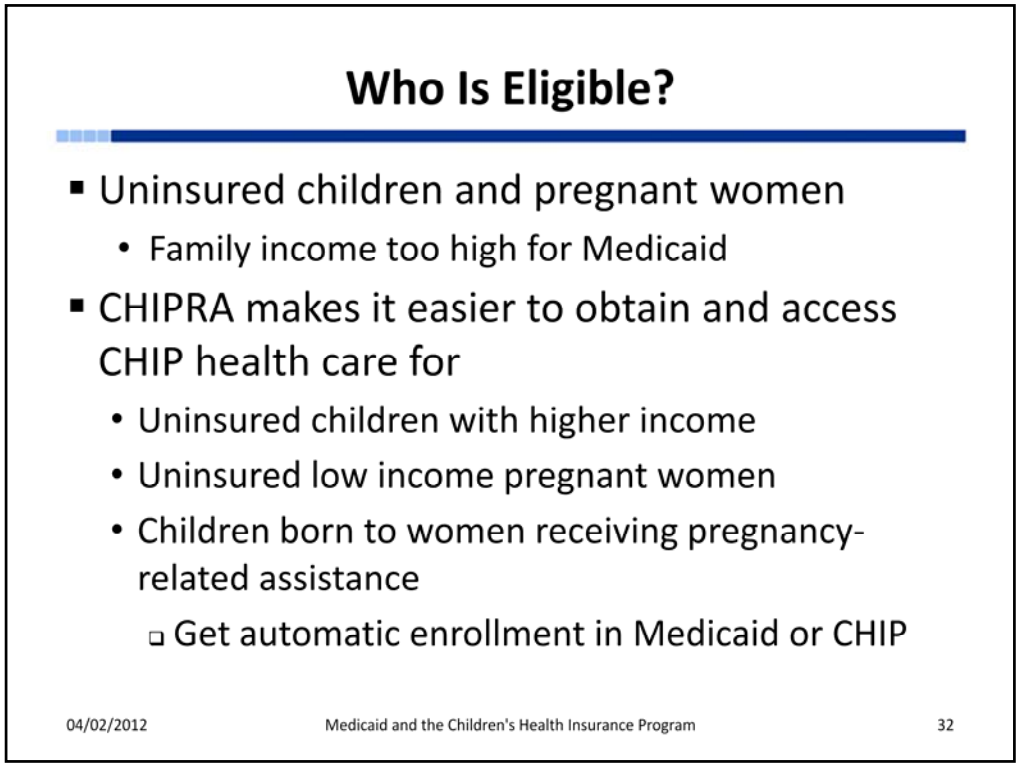


Here are some basic facts about the CHIP program:

- The program gives each state authority to provide health insurance for children, up to age 19, who are not already insured (within limitations) and who meet other requirements.
- CHIP is a partnership with the states who administer their program within the Federal guidelines.
- Because each state sets its own guidelines, there is not one nationwide SCHIP/CHIP program but all must meet certain Federal parameters.
- Unlike Medicaid, CHIP has never been an entitlement program. CHIPRA does not change that status.

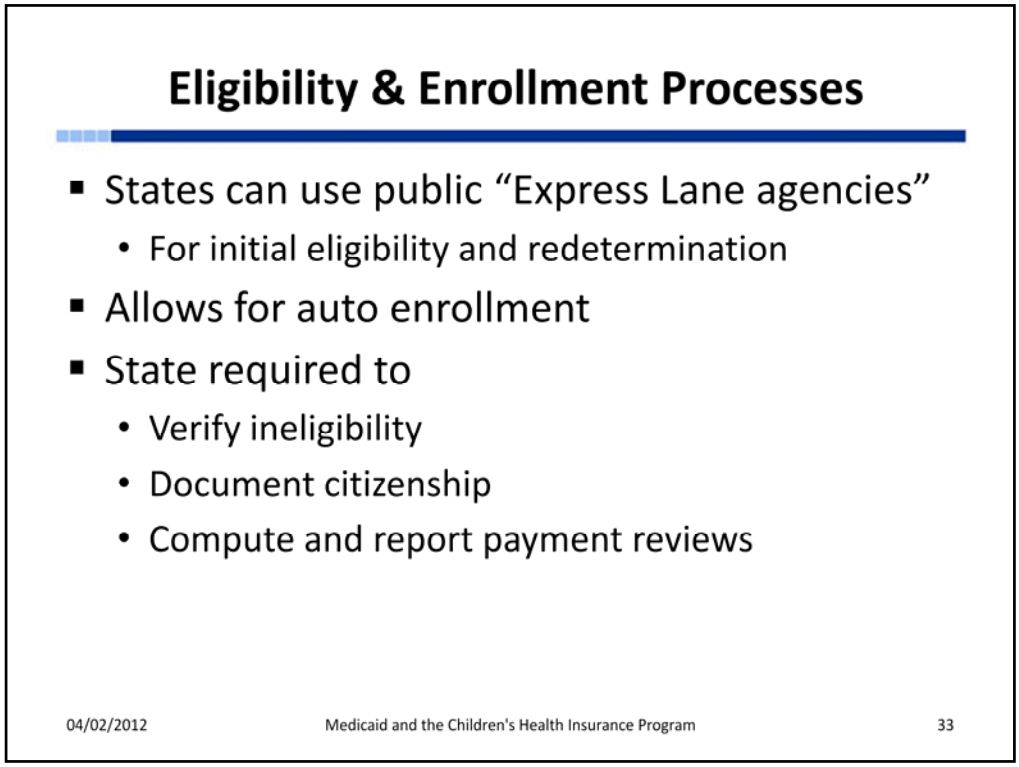


This chart shows the design of the CHIP programs chosen by each state and the U.S. Territories as of September, 2011.



Uninsured children and pregnant women with family income that is too high for Medicaid may be eligible for CHIP. The CHIPRA legislation makes it easier for certain groups to obtain and access CHIP health care. These include

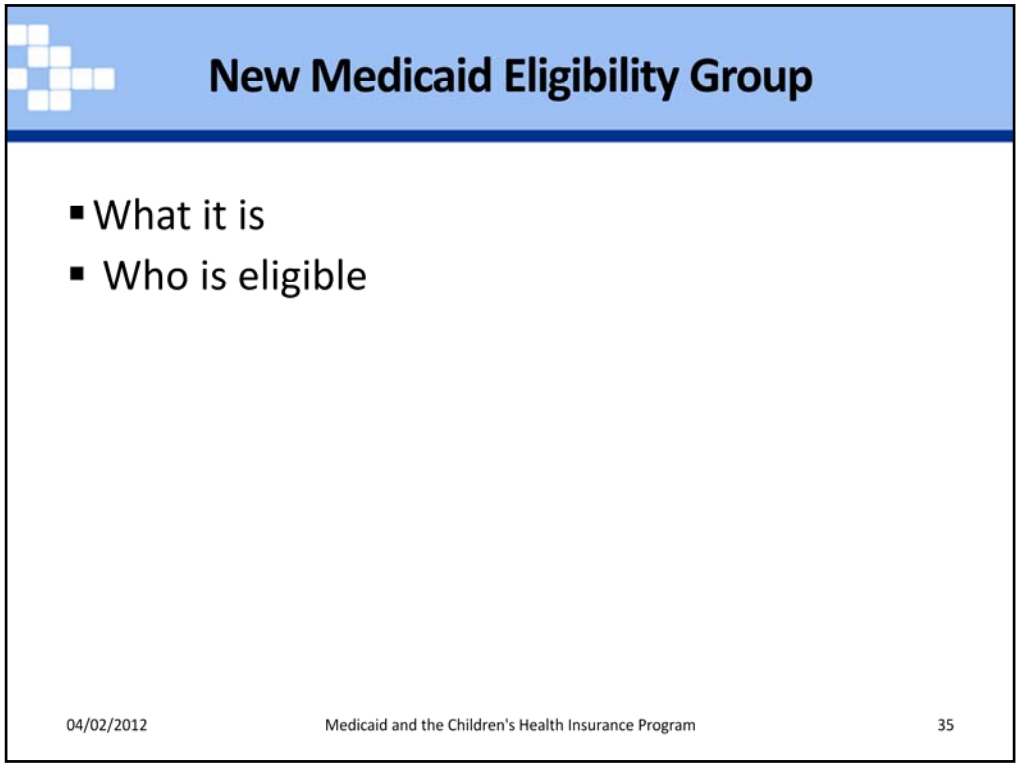
- Uninsured children with higher income
- Uninsured low income pregnant women
- Automatic enrollment in Medicaid or CHIP for children born to women receiving pregnancy-related assistance



CHIPRA allows states to use public agencies and their application and eligibility determination process for initial eligibility determination and redetermination for Medicaid and CHIP. These are called "Express Lane agencies." CHIPRA also allows for the option to auto enroll without a signature or application form. The child's parent or guardian must consent to enrollment. States are required to

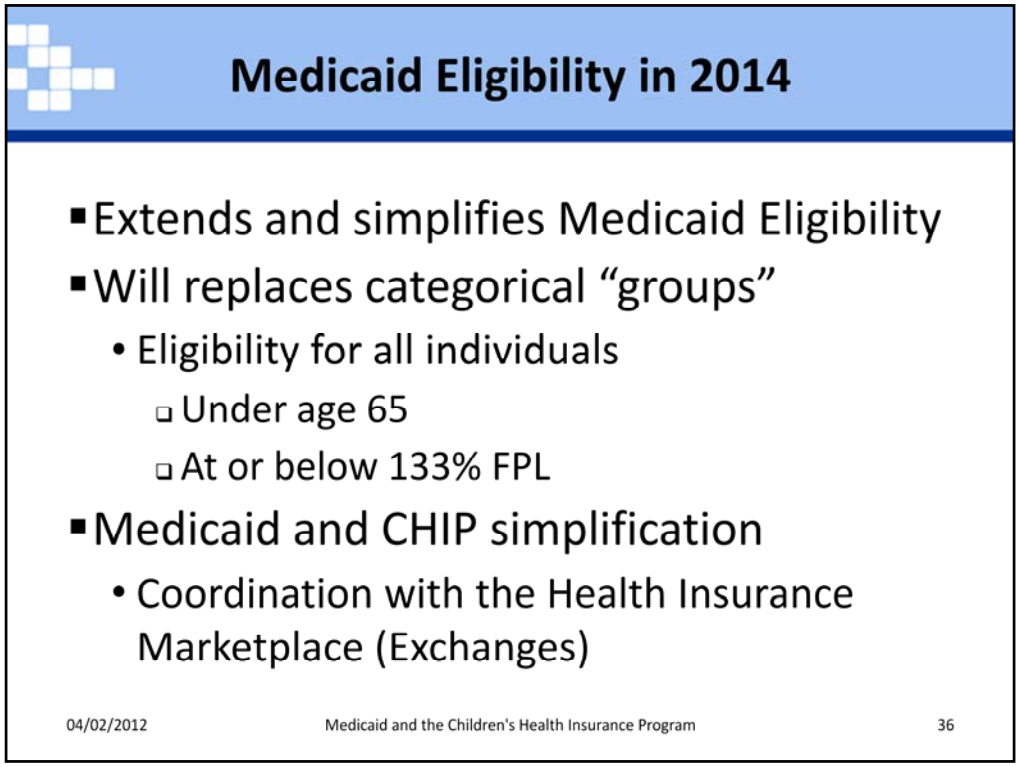
- Verify ineligibility (check the accuracy of the information provided to the Express Lane agency)
- Document citizenship (still required)
- Compute and report payment reviews

CHIPRA gave states the option to lift the five-year ban on covering legal immigrants, applies citizenship documentation requirements to CHIP, deems Tribal Membership and enrollment documents to satisfy citizenship and identity requirements except for tribes with international borders whose members are not U.S. citizens. These changes are retroactive to 2006.



This section explains the New Medicaid Eligibility Group.

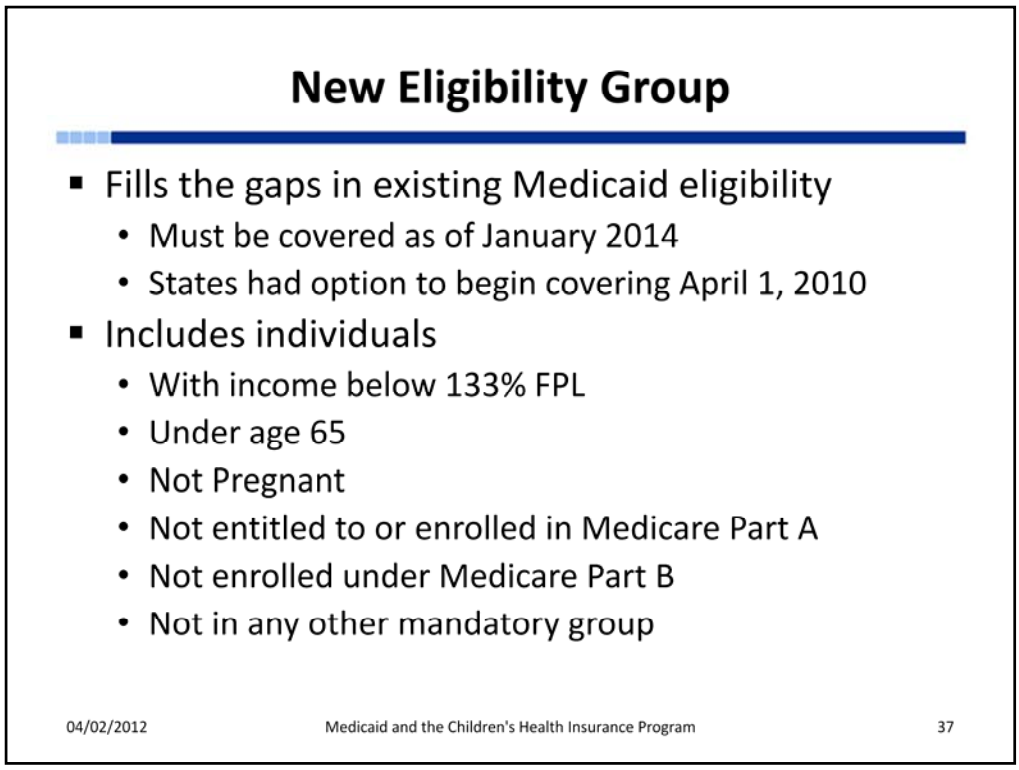
- What it is
- Who is eligible



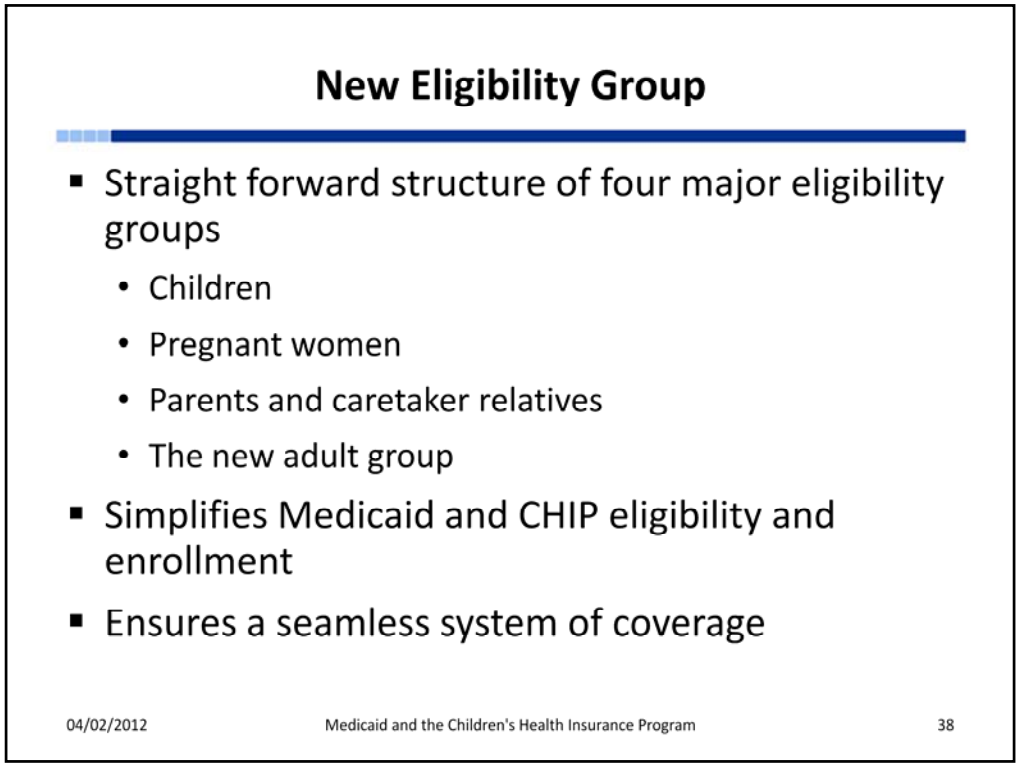
Prior to the implementation of the Affordable Care Act in 2014, individuals who fall into certain categories' or categorical "groups'' are eligible for Medicaid, including low-income children, pregnant women, parents and other caretaker relatives, seniors, and people with disabilities.

Federal minimum income eligibility standards vary by category. States could not cover non-disabled, non-elderly adults who do not have dependent children, regardless of their income level, except through a Medicaid demonstration under Section 1115 of the Act. As a result of the varying Federal minimum standards and State options, eligibility for Medicaid is complicated and significant gaps continue to exist even among the lowest income Americans.

The Affordable Care Act fills in current gaps in coverage for the poorest Americans by creating a minimum Medicaid income eligibility level across the country. Beginning in January 2014, individuals under 65 years of age with income below 133 percent of the federal poverty level (FPL) will be eligible for Medicaid. For the first time, low-income adults without children will be guaranteed coverage through Medicaid in every state without need for a waiver, and parents of children will be eligible at a uniform income level across all states. Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment will be much simpler and will be coordinated with the newly created Health Insurance Marketplace (Exchanges).



ACA established a new eligibility group that all states participating in Medicaid must cover as of January 2014. This new group fills in the gaps in existing Medicaid eligibility. It makes eligible very-low income individuals (those under 133% FPL) who aren't otherwise eligible under mandatory eligibility categories. It includes those who are not age 65 or older; pregnant; entitled to or enrolled in benefits under Medicare Part A; enrolled under Medicare Part B; or described in any of the other mandatory groups in the statute, such as certain parents, children, or people eligible based on their receipt of benefits under the Supplemental Security Income (SSI) program. States have the option to begin covering this group or to phase-in coverage of the group based on income starting April 1, 2010.



To establish a foundation for a more simplified, streamlined Medicaid eligibility process in the context of the new eligibility group for low-income adults that will become effective in 2014, The Medicaid Eligibility Final Rule (released on March 16, 2012) implements a more straightforward structure of four major eligibility groups: children, pregnant women, parents and caretaker relatives, and the new adult group. The final rule codifies Medicaid and CHIP eligibility and enrollment simplification processes to ensure a seamless system of coverage.

Beginning in January 2014, individuals under 65 years of age with income below 133 percent of the federal poverty level (FPL) will be eligible for Medicaid. For the first time, low-income adults without children will be guaranteed coverage through Medicaid in every state without need for a waiver, and parents of children will be eligible at a uniform income level across all states.

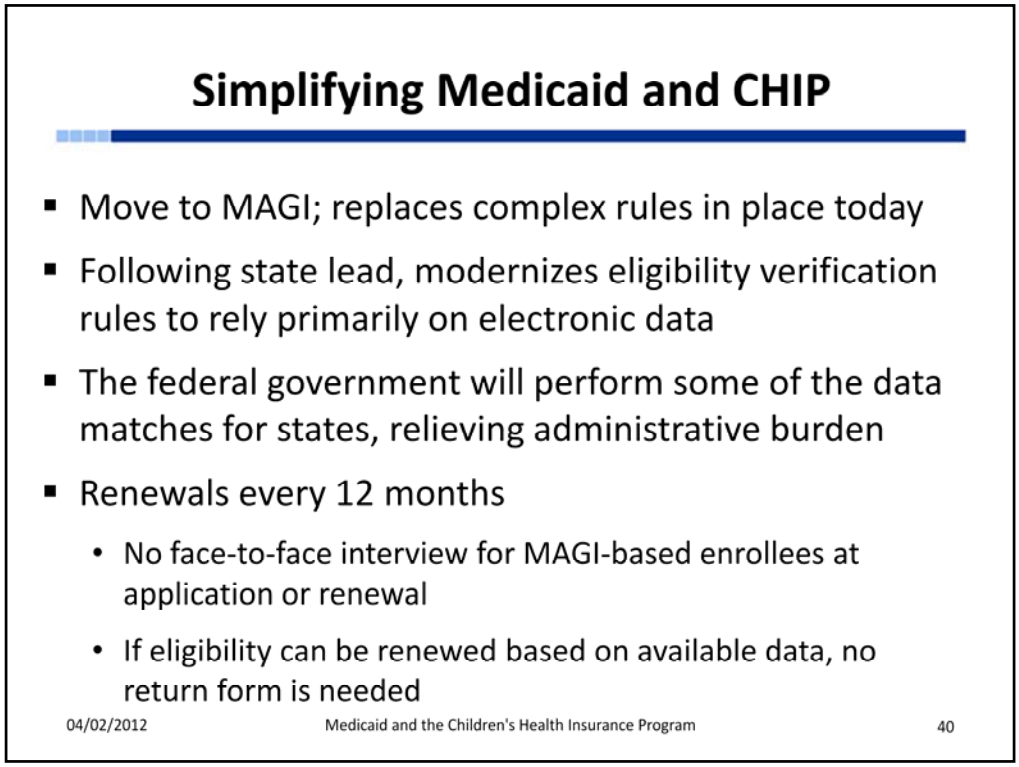
The Final Rule also simplifies financial eligibility by relying on a single "Modified Adjusted Gross Income" (MAGI) standard for determining eligibility for most Medicaid and CHIP enrollees (children and non-disabled adults under age 65) and by consolidating eligibility categories into four main groups – adults, children, parents and pregnant women. (See chart on next slide).

In addition, people with disabilities or in need of long-term services and supports may enroll in an existing Medicaid eligibility category to ensure that they are quickly enrolled in coverage that best meets their needs.

Minimum Medicaid Eligibility Levels Now and 2014

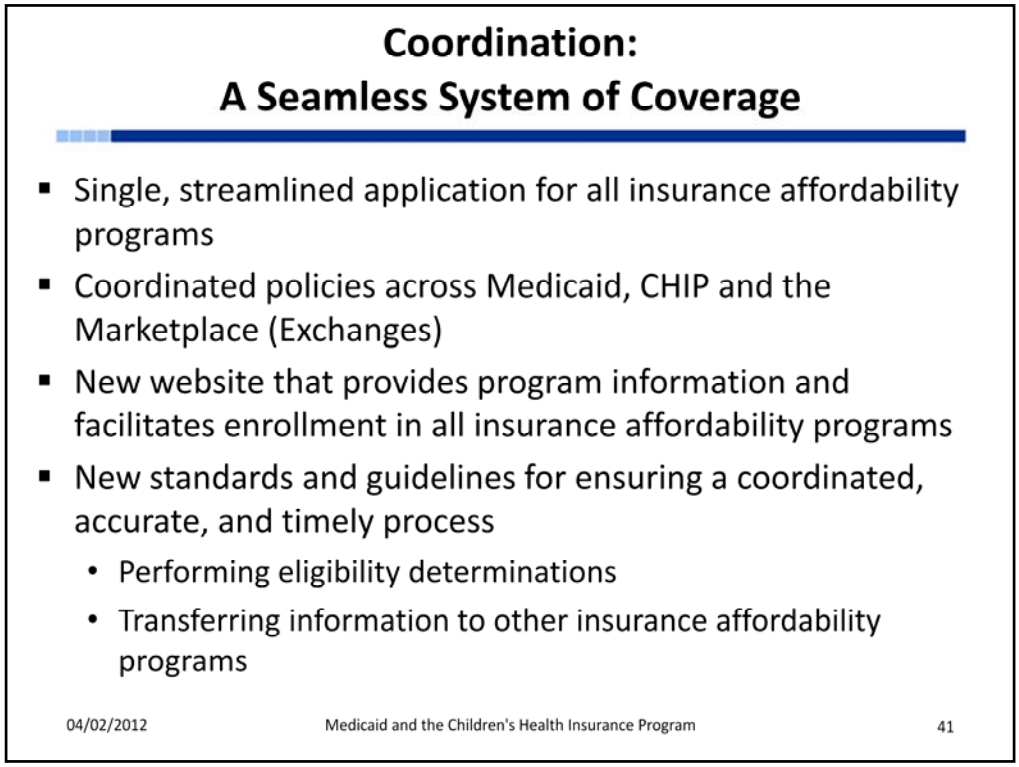
Population	Current Minimum Eligibility Levels	2014 Minimum Eligibility Levels
Children & Pregnant Women	100%/133% (Average =241%)	≥ 133% (Varies by state)
Parents	Varies by state (Average = 64%)	133%
Disabled Adults	74% (SSI-related)	133%
Other Adults	0%*	133%

•Five states provide Medicaid or Medicaid look-alike coverage to certain childless adults; 15 states provide a limited benefit package to certain childless adults.



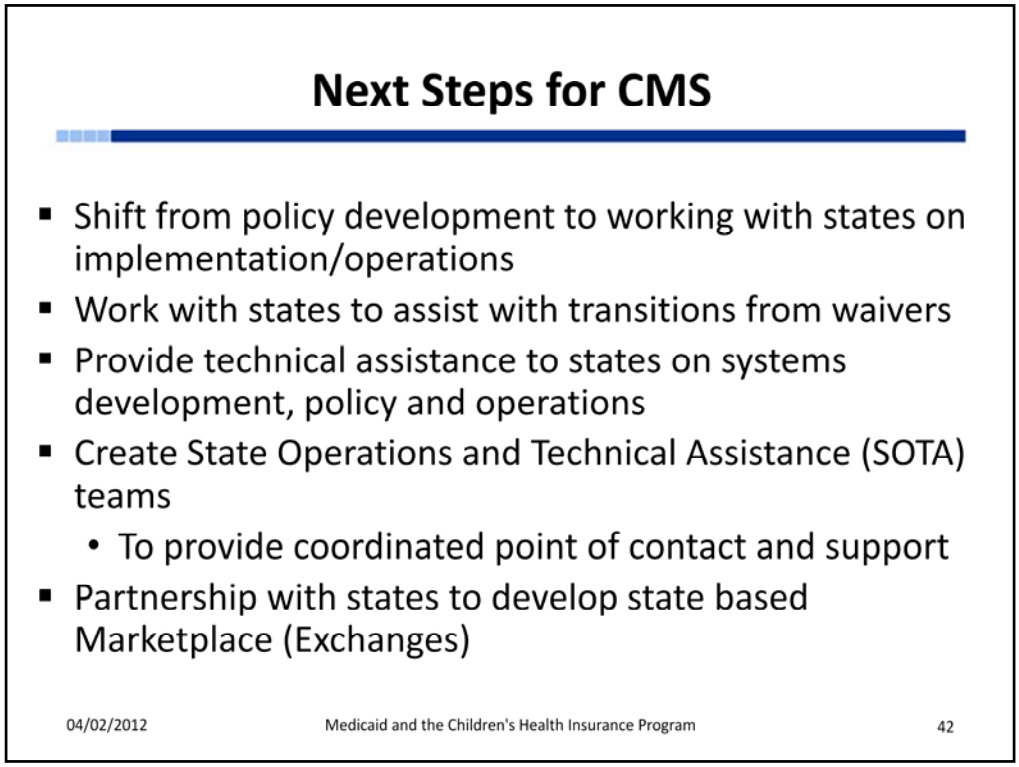
New Rule simplifies the Medicaid and CHIP eligibility, enrollment and renewal process in the following ways:

- Replaces complex rules in place today with the new Modified Adjusted Gross Income (MAGI) standard, ensuring that individuals eligible under the MAGI-based category will be promptly enrolled in Medicaid.
- Modernizes eligibility verification procedures to rely primarily on electronic data sources while providing states flexibility to determine the usefulness of available data before requesting additional information from applicants, and simplifying verification procedures for states through the operation of a federal data services “Hub” that will link states with federal data sources (e.g. Social Security and Homeland Security).
- Codifies current Medicaid policy so that eligibility is renewed by first evaluating the information available through existing data sources and limits renewals for the people enrolled through the simplified, income-based rules to once every 12 months unless the individual reports a change or the agency has information to prompt a reassessment of eligibility.



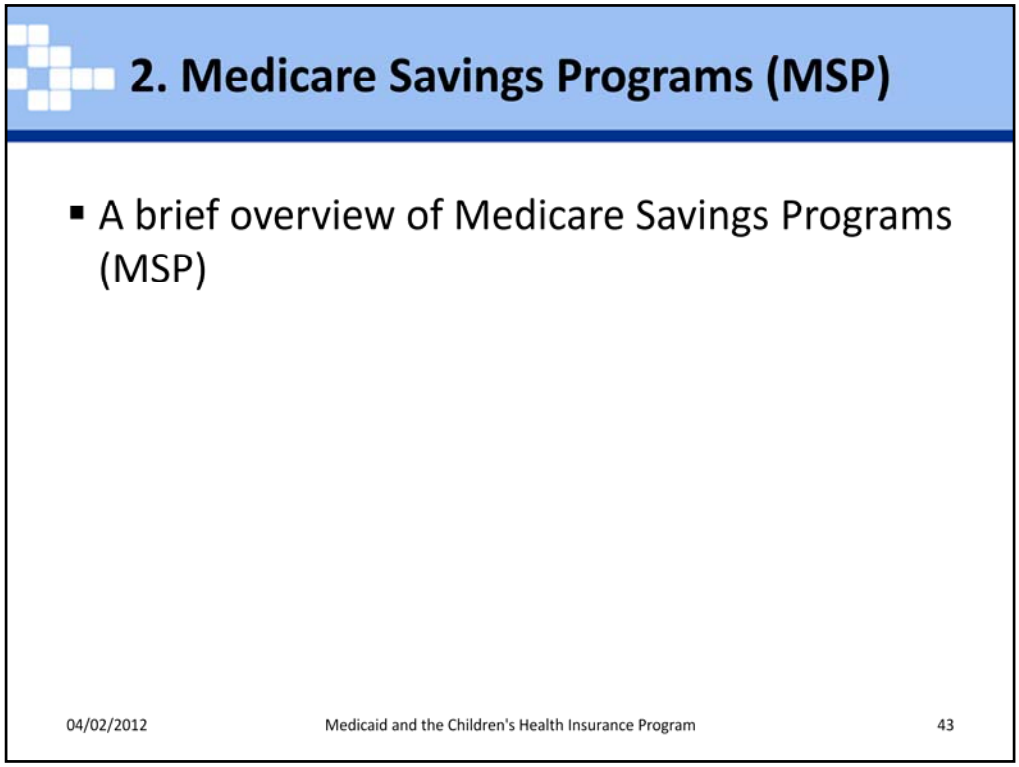
The new rules implement the following:

- A single, streamlined application for all insurance affordability programs
- Coordinated policies across Medicaid, CHIP and the Exchanges
- Set new standards and guidelines for ensuring a coordinated, accurate and timely process for performing eligibility determinations and transferring information to other insurance affordability programs
- A website that provides program information and facilitates enrollment in all insurance affordability programs

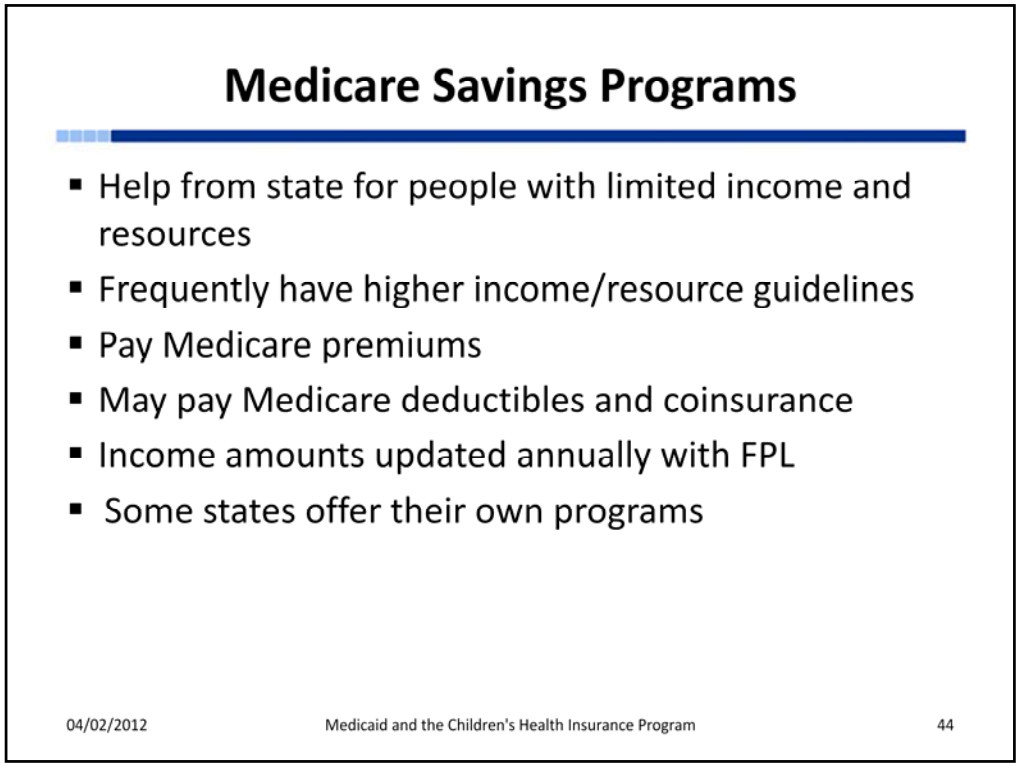


Moving forward CMS goals are to

- Shift from policy development to working with states on implementation/operations
- Assist states with transitions from waivers to the simplified eligibility groups
- Provide technical assistance for states on systems development, policy and operations, other issues as they emerge
- Create a multi-disciplinary State Operations and Technical Assistance (SOTA) teams to provide coordinated point of contact and support
- Work in partnership with states to develop the state based Exchanges



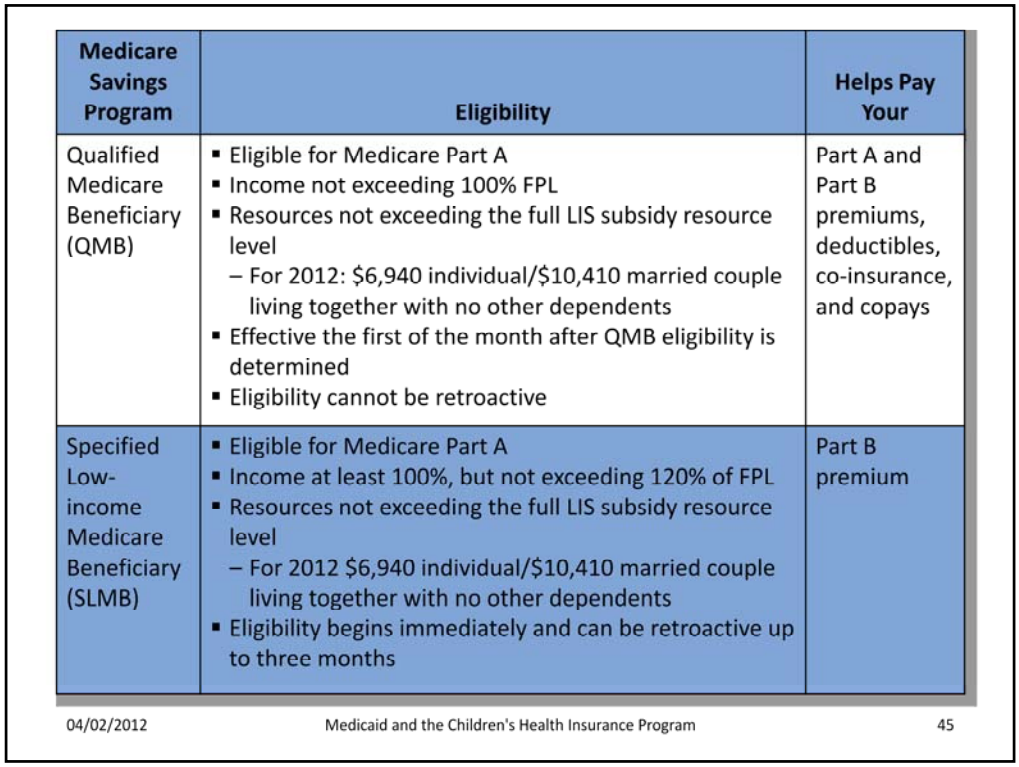
Medicare Savings Programs (MSP) explains programs that help pay Medicare costs for people with limited income and resources.



States have other programs that pay Medicare premiums and, in some cases, may also pay Medicare deductibles and coinsurance for people with limited income and resources. These programs frequently have higher income and resource guidelines than Medicaid and are called Medicare Savings Programs. Eligibility for these programs is determined by income and resource levels. The income amounts are updated annually with the Federal poverty level.

Additionally, some states offer their own programs to help people with Medicare pay the out-of-pocket costs of health care, including State Pharmacy Assistance Programs.

You can contact your local Medicaid office or the State Health Insurance Assistance Program (SHIP) in your state to find out which programs may be available to you. You can find the contact information for your local SHIP by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

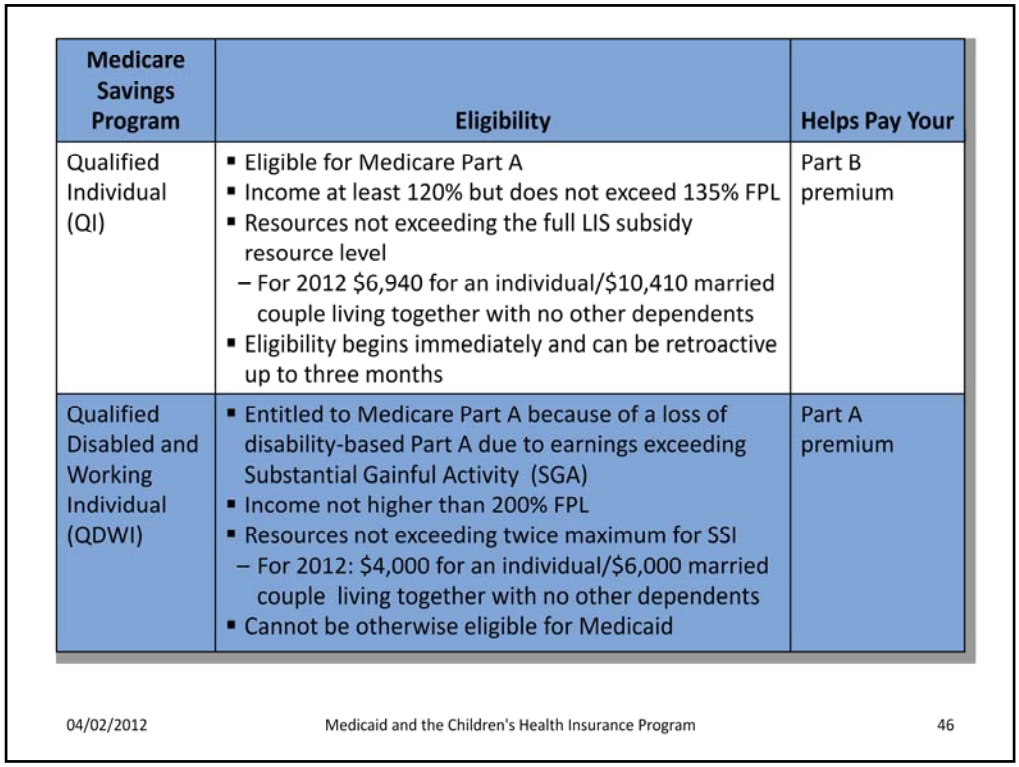


Medicare Savings Program	Eligibility	Helps Pay Your
Qualified Medicare Beneficiary (QMB)	▪ Eligible for Medicare Part A ▪ Income not exceeding 100% FPL ▪ Resources not exceeding the full LIS subsidy resource level – For 2012: $6,940 individual/$10,410 married couple living together with no other dependents ▪ Effective the first of the month after QMB eligibility is determined ▪ Eligibility cannot be retroactive	Part A and Part B premiums, deductibles, co-insurance, and copays
Specified Low-income Medicare Beneficiary (SLMB)	▪ Eligible for Medicare Part A ▪ Income at least 100%, but not exceeding 120% of FPL ▪ Resources not exceeding the full LIS subsidy resource level – For 2012 $6,940 individual/$10,410 married couple living together with no other dependents ▪ Eligibility begins immediately and can be retroactive up to three months	Part B premium

The Qualified Medicare Beneficiary (QMB) program was established by the Medicare Catastrophic Coverage Act of 1988. To qualify for QMB you must be eligible for Medicare Part A, and have an income not exceeding 100% of the Federal Poverty Level (FPL). This will be effective the first month following the month QMB eligibility is approved. Eligibility cannot be retroactive. If you qualify for QMB, you get help paying your Part A and Part B premiums, deductibles, co-insurance, and copays.

The Specified Low-income Medicare Beneficiary (SLMB) program was established by OBRA law of 1990 and became effective January 1, 1993. To qualify for SLMB, you must be eligible for Medicare Part A and have an income that is at least 100%, but does not exceed 120% of the FPL. If you qualify for SLMB, you get help paying for your Part B premium.

Note: Effective January 1, 2012, the resource limits for the QMB, SLMB and QI programs are $6,940 for a single person and $10,410 for a married person living with a spouse and no other dependents. These resource limits are adjusted on January 1 of each year, based upon the change in the annual consumer price index (CPI) since September of the previous year. States must use the new resource limits when determining eligibility for these programs.

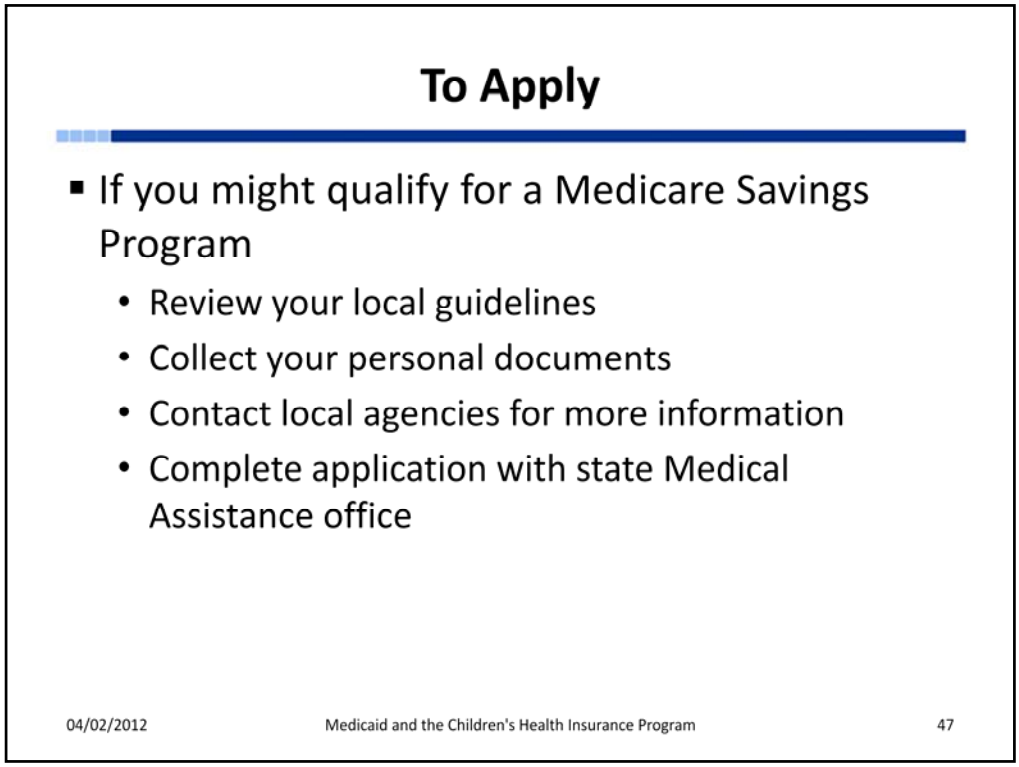


Medicare Savings Program	Eligibility	Helps Pay Your
Qualified Individual (QI)	▪ Eligible for Medicare Part A ▪ Income at least 120% but does not exceed 135% FPL ▪ Resources not exceeding the full LIS subsidy resource level – For 2012 $6,940 for an individual/$10,410 married couple living together with no other dependents ▪ Eligibility begins immediately and can be retroactive up to three months	Part B premium
Qualified Disabled and Working Individual (QDWI)	▪ Entitled to Medicare Part A because of a loss of disability-based Part A due to earnings exceeding Substantial Gainful Activity (SGA) ▪ Income not higher than 200% FPL ▪ Resources not exceeding twice maximum for SSI – For 2012: $4,000 for an individual/$6,000 married couple living together with no other dependents ▪ Cannot be otherwise eligible for Medicaid	Part A premium

The Qualified Individual (QI) program was established by the BBA of 1997. It is fully Federal funded. Congress only appropriated a limited amount of funds to each state. To qualify for QI, you must be eligible for Medicare Part A, and have an income not exceeding 135% of the Federal Poverty Level (FPL). If you qualify for QI, and there are still funds available in your state, you get help paying your Part B premium.

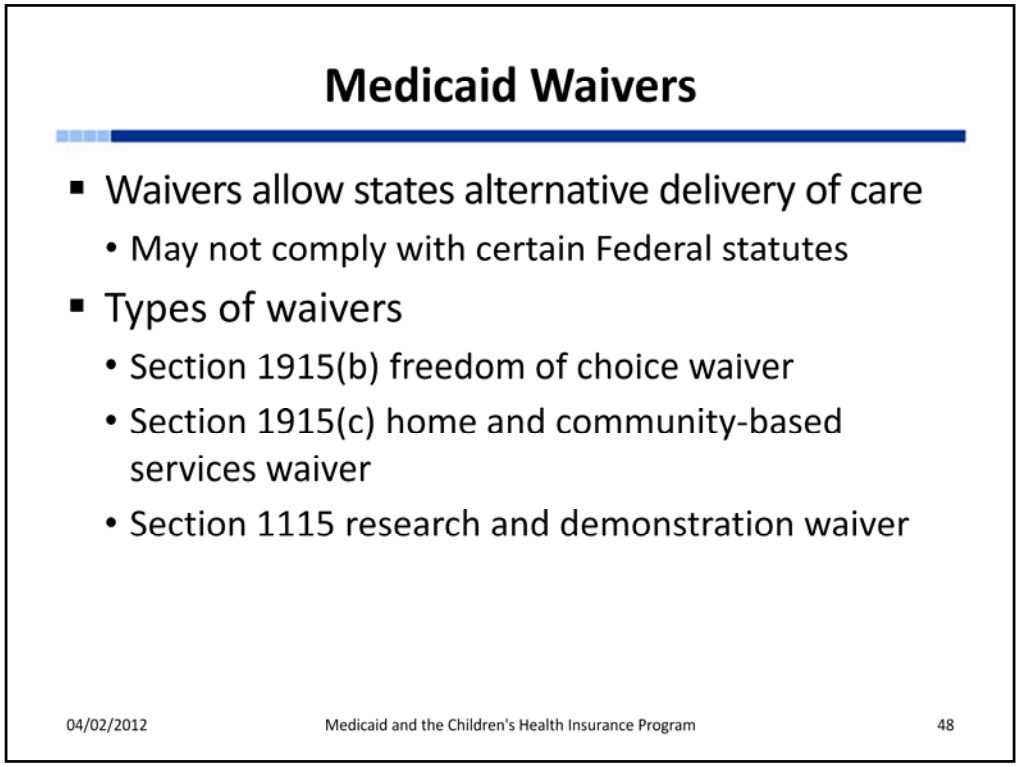
The Qualified Disabled and Working Individual (QDWI) program was established by the OBRA law of 1989. To qualify for QDWI, you must be entitled to Medicare Part A because of a loss of disability-based Part A due to earnings exceeding Substantial Gainful Activity (SGA), and have an income not higher than 200% of the FPL, and you cannot be otherwise eligible for Medicaid. If you qualify you get help paying your Part A premium. States can charge premiums if income is between 150% and 200% FPL. Resources not exceeding twice maximum for SSI (in 2012 $4,000 for an individual and $6,000 for married couple).

NOTE: This chart is provided as a handout in the corresponding workbook's Appendix.



Here are some steps you can take to find out if you qualify for help with your Medicare out-of-pocket expenses:

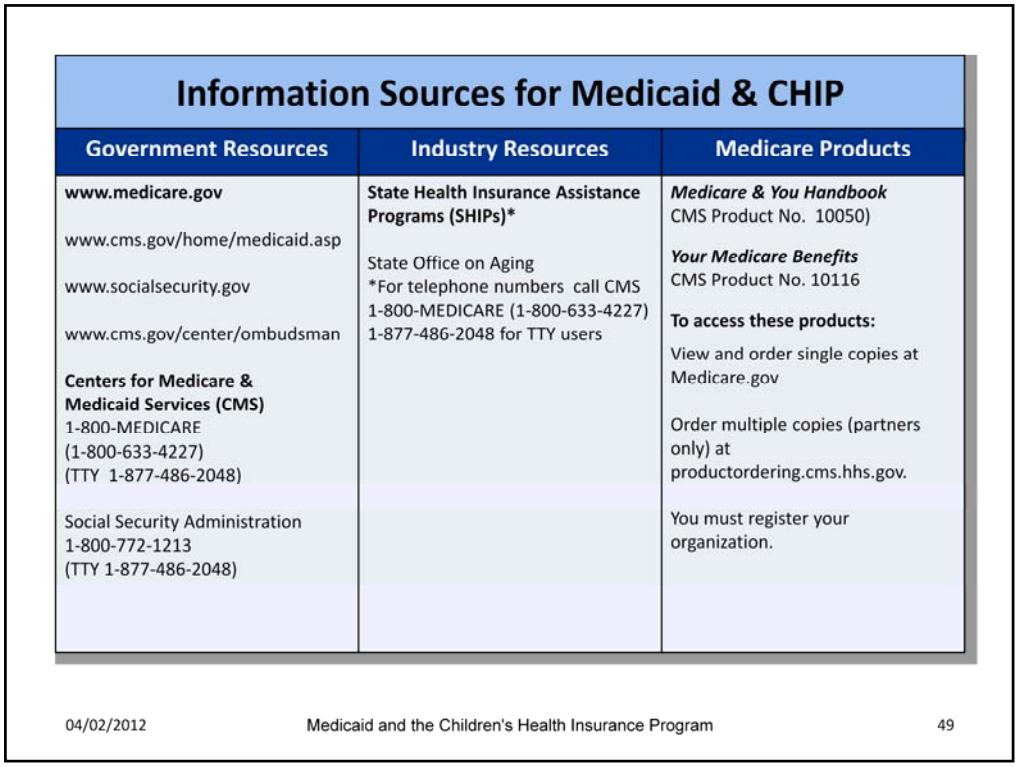
- First, review the income and resource (or asset) guidelines for your area.
- If you think you may qualify, collect the personal documents the agency requires for the application process. You will need the following:
  - Medicare card
  - Proof of identity
  - Proof of residence
  - Proof of any income, including pension checks, Social Security payments, etc.
  - Recent bank statements
  - Property deeds
  - Insurance policies
  - Financial statements for bonds or stocks
  - Proof of funeral or burial policies
- You can get more information by contacting your state Medical Assistance office, your local SHIP program, or your local Area Agency on Aging.
- Finally, complete an application with your state Medical Assistance office.



Medicaid waivers allow the state to receive Federal Medicaid matching funds for its expenditures that normally would not be covered, even though it is no longer in compliance with certain requirements or limitations of the Federal Medicaid statute.

Waivers allow states alternatives to delivering care from traditional Medicaid.

- Section 1915(b) waivers—states may restrict the choice of providers that Medicaid beneficiaries would otherwise have.
- Program waivers such as the 1915(c) waiver for home-and community-based services—states may receive Federal matching funds for services for which Federal matching funds are not otherwise available. 1915(c) waiver services can be provided to Medicaid eligible individuals who meet an institutional level of care.
- Demonstration waivers such as the section 1115 waivers—states may receive Federal matching funds for covering certain categories of individuals for which Federal matching funds are not otherwise available.



Government resources for more information

Call the Centers for Medicare & Medicaid Services (CMS), 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Beneficiary Information is available on Medicare.gov

Call the Social Security Administration (SSA), 1-800-772-1213. TTY users call 1-877-486-2048.

Information on the Medicaid program is available on cms.gov/home/medicaid.asp

Partner information is available on CMS.gov

Industry resources for more information

Contact your State Health Insurance Assistance Program (SHIP) and/or your State Office on Aging. For telephone numbers, call CMS 1-800-MEDICARE (1-800-633-4227). TTY user call 1-877-486-2048.

Medicare Products

*Medicare & You Handbook, C*MS Product No. 10050

Your Medicare Benefits, CMS Product No. 10116

Note: View and order single copies at www.Medicare.gov. Order multiple copies (partners only) at productordering.cms.hhs.gov. You must register your organization.

This training module is provided by the National Medicare Training Program.

For questions about training products, e-mail NMTP@cms.hhs.gov

To view all available NMTP materials or to subscribe to our listserv, visit https://public.govdelivery.com/accounts/USCMS/subscriber/new?

Medicare Savings Program	Eligibility	Helps Pay Your
Qualified Medicare Beneficiary (QMB)	▪ Eligible for Medicare Part A ▪ Income not exceeding 100% FPL ▪ Resources not exceeding the full LIS subsidy resource level – For 2012: $6,940 individual/$10,410 married couple living together with no other dependents ▪ Effective the first of the month after QMB eligibility is determined ▪ Eligibility cannot be retroactive	Part A and Part B premiums, deductibles, co-insurance, and copays
Specified Low-income Medicare Beneficiary (SLMB)	▪ Eligible for Medicare Part A ▪ Income at least 100%, but not exceeding 120% of FPL ▪ Resources not exceeding the full LIS subsidy resource level – For 2012 $6,940 individual/$10,410 married couple living together with no other dependents ▪ Eligibility begins immediately and can be retroactive up to three months	Part B premium

Medicare Savings Program	Eligibility	Helps Pay Your
Qualified Individual (QI)	▪ Eligible for Medicare Part A ▪ Income at least 120% but does not exceed 135% FPL ▪ Resources not exceeding the full LIS subsidy resource level – For 2012 $6,940 for an individual/$10,410 married couple living together with no other dependents ▪ Eligibility begins immediately and can be retroactive up to three months	Part B premium
Qualified Disabled and Working Individual (QDWI)	▪ Entitled to Medicare Part A because of a loss of disability-based Part A due to earnings exceeding Substantial Gainful Activity (SGA) ▪ Income not higher than 200% FPL ▪ Resources not exceeding twice maximum for SSI – For 2012: $4,000 for an individual/$6,000 married couple living together with no other dependents ▪ Cannot be otherwise eligible for Medicaid	Part A premium

E-mail: NMTP@cms.hhs.gov
Website:cms.gov/Outreach-and-Education/Training/NationalMedicareProgTrain/

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244